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14. ABSTRACT <p>This project implemented and assessed the feasibility of TEAM (Troop Education for Army Morale) a unique Psychological First Aid-based post deployment intervention designed to meet the needs of Mortuary Affairs (MA) Soldiers through individual training, buddy care and spouse support. Ten cohorts ($N = 126$ MA Soldiers) were randomized into intervention and comparison groups. Intervention groups received interactive group sessions at 2, 3, 4 and 7 months post deployment, handouts, a website, phone line and email service. Intervention and comparison groups completed assessments at 1, 2, 3, 4, 7 and 10 months. At baseline, 25.0% had probable PTSD and 23.6% had probable depression. Higher rates of PTSD were associated with living with a spouse or having children. Higher rates of depression were associated with being female, married, having children, and higher education. Mixed modeling analysis found a time by treatment effect of the intervention on PTSD symptoms, a marginal effect of time on depression symptoms, and no differences in quality of life. Overall, the intervention was well accepted, reported to be helpful in specific areas, but had little effect on disorder.</p>					
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Introduction

U.S. Army Mortuary Affairs (MA) soldiers are exposed to death and the combat environment and are at high risk for PTSD, depression and health risk behaviors. No empirically informed interventions have been developed to address the needs of this high risk group. The objective of this project was to implement and assess the feasibility of a unique and newly-developed intervention (TEAM: Troop Education for Army Morale) designed to meet the specific needs of MA Soldiers for early and follow-up intervention to speed recovery, return to work and limit barriers to care through individual training, active engagement in problem solving and accessing care, enhanced buddy care and spouse support. Specific aims included: 1) demonstrating the feasibility of TEAM intervention for care, support and lessening barriers to care for MA Soldiers and 2) assessing the effectiveness of TEAM on disorder (e.g., PTSD, depression), distress, health risk behaviors (e.g., alcohol or tobacco use), work function, marital conflict, and barriers to health care utilization. Results contribute to a greater understanding of the effectiveness of early interventions with high risk military populations and have implications for interventions with disaster workers and others exposed to the dead.

Keywords

US Army, soldier, mortuary affairs soldiers, deployment, post traumatic stress disorder (PTSD), intervention, Psychological First Aid, Skills for Psychological Recovery, Cognitive Behavioral Therapy

Overall Project Summary

Summary of Project Tasks as identified in the SOW

- 1. Coordination planning with site/units.** Project members established and sustained frequent contact with Fort Lee Command and Mortuary Affairs units to maintain support for TEAM and plan for recruitment and intervention sessions. Institutional regulatory review was obtained and maintained from the Uniformed Services University and Fort Detrick IRBs. Study clinicians and staff completed and maintained human subjects training requirements.
- 2. Personnel recruitment, hiring and training.** The project was fully staffed. Members of the project were trained on the use of the intervention materials (e.g., intervention manual, slides, handouts) as well as the means of delivering the educational content (e.g., conducting group intervention sessions, use of the phone line and email service, and participant safeguards).
- 3. Development of short and long-term intervention and assessment.** Intervention materials for Soldiers in the intervention group and participating spouses were developed. They include a detailed intervention handbook for instructors (see Appendix B2), PowerPoint slides, a dedicated website (see Appendix D1), and informational handouts (see Appendices C7 – C18 and D2 – D13). The intervention's educational content includes skills for care of self and others (buddy/spouse) and whenever possible is targeted to the special needs of MA Soldiers and/or their spouses. The intervention materials are based on Psychological First Aid and address barriers to seeking care, managing resistance and accessing care. The website content mirrored and supported the group intervention session content. PowerPoint slides and handouts covering material from each group

session were placed on the website for 24/7 access, which was particularly important for participants who may have missed a group session. A TEAM email address and a toll free phone line were established for purposes of educational support of intervention group participants and their participating spouses. Assessments (evaluations) were developed for all assessment periods for intervention and comparison groups (see Appendices E1 – E4). Assessments were reviewed by a project consultant for utility and ease of understanding.

4. Develop participant tracking system. A data base structure for data entry and organization of recruitment and tracking was built.

5. Feasibility study and recruitment coordination. Assessment and intervention materials (e.g., intervention handbook, handouts) were reviewed by a consultant prior to finalization. Pilot testing of all aspects of TEAM materials, procedures and logistics was complete as planned. Fort Lee Command and Mortuary Affairs units supported the TEAM program and were cooperative in arranging availability of subjects and space for conducting workshops at Fort Lee, VA.

6. Intervention and assessments, ongoing data preparation. Recruitment of the first cohort of subjects ($N = 21$; 11 in intervention group, 10 in comparison group) began in July 2009 and they completed the final assessment in June 2010. TEAM intervention materials, assessments, procedures and logistics were evaluated and optimized throughout cohort 1. Cohort 2 ($N = 31$; 16 intervention, 15 comparison) was recruited in December 2009 and completed the final assessment in September 2010. Cohort 3 ($N = 23$; 12 intervention, 11 comparison) was recruited in June 2010 and completed the final assessment in January 2011. Cohort 4 ($N = 12$; 7 intervention, 5 comparison) was recruited in November 2010

and completed the final assessment in October 2011. Cohort 5 ($N = 3$; 2 intervention, 1 comparison) was recruited in May 2011 and completed the final assessment in April 2012. Cohort 6 ($N = 4$; 4 intervention, 0 comparison) was recruited in October 2011 and completed the final assessment in July 2012. Cohort 7 ($N = 11$; 7 intervention, 4 comparison) was recruited in April 2012 and completed the final assessment in February 2013. Cohort 8 ($N = 12$; 7 intervention, 5 comparison) was recruited in January 2013 and completed the final assessment in March 2014. Cohort 9 ($N = 12$; 6 intervention, 6 comparison) was recruited in June 2013 and completed the final assessment in July 2014. Cohort 10 ($N = 6$; 4 intervention, 2 comparison) was recruited in December 2013 and completed the final assessment in July 2014. Assessment data were entered into the subject-tracking database and cleaned prior to statistical analysis.

7. Complete subject recruitment, intervention and assessment. Subject recruitment (soldiers and spouses) commenced in December 2013. Over the course of the project there were 135 enrollments. This included nine soldiers who had been in the comparison group and re-enrolled in TEAM on a subsequent return from deployment and were placed in the intervention group. Spouse participation was lower than anticipated; two spouses participated in TEAM. The last intervention session was held in June 2014 and final assessments took place in July 2014.

8. Data preparation. All collected data were entered into the database. The data were checked for errors as it was entered. SAS programs were written and tested in preparation for data analysis.

9. Preparation for project conference. Materials were prepared and organized for the final project conference.

10. Data analysis. Of the 135 enrollments, data from nine soldiers' second enrollment and data from one intervention group soldier who stopped participation were not included in data analysis. Thus, data analysis included 125 soldiers, 67 in the intervention group and 58 in the comparison group. All data were checked and quality assessed in preparation for data analysis. Univariate, bivariate and linear mixed modeling analyses were performed. Data were tabled and prepared for presentation at the final project conference and manuscript publication.

11. Final project conference. Project members convened to present the findings and review the impact of the intervention. Conference materials were sent to consultants (e.g., Doug Zatzick, M.D.) who were not available to attend the conference in-person and feedback was received.

12. Preparation and delivery/distribution of final report. Results were written-up and are prepared for submission to a peer reviewed journal. Project goals, plans for analyses of existing data, and plans for future research have been reviewed.

Background and Significance

The emotional cost of military deployment can be high (Cigrang et al., 2014; Hoge et al., 2004; Prigerson, Maciejewski & Rosenheck, 2002; Ursano & Norwood, 1996). Deployment stressors include risk to life, exposure to combat and casualties and family disruption. Deployed US Army mortuary affairs (MA) soldiers experience deployment stressors as well as exposure to death and the dead, body recovery and identification, and dealing with bereaved families. Studies have documented the psychological effects of working with human remains on military personnel and disaster workers (Bryant & Harvey, 1996; Clohessy & Ehlers, 1999; Fullerton,

McCarroll, Ursano, & Wright, 1992; Leffler & Dembert, 1998; Marmar, Weiss, Metzler, Ronfeldt, & Foreman, 1996; McCarroll, Ursano, & Fullerton, 1993; 1995; Regehr, Hill, & Glancy, 2000; Sutker, Uddo, Brailey, Vasterling, & Errera, 1994b). Recovery and identification of human remains are associated with acute and long-term psychological distress and psychiatric disorders regardless of training and prior experience (Green, Lindy, Grace, Gleser, 1989; Labbate, Cardena, Dimitreva, Roy, & Engel, 1998; McCarroll, et al., 1993, 1995; McCarroll, Ursano, Fullerton, Liu & Lundy, 2001; 2002; Miles, Demi & Mostyn-Aker, 1984; Sutker et al., 1994b). To date, no interventions have been developed specifically for MA soldiers returning from deployment.

Several evidence-informed interventions have been used with military as well as disaster populations. Psychological First Aid (PFA) is designed to reduce initial distress following traumatic events and facilitate positive adaptation by promoting five principles: (a) sense of safety (physical and psychological), (b) calming, (c) connectedness, (d) sense of self- and community efficacy, and (e) hope/optimism (Hobfoll et al., 2007; NCPTSD, NCTSN, 2006; Vernberg et al., 2008). These principles are widely supported by expert opinion (Fox et al., 2012) and have been incorporated into policy and practice as a primary public health approach to trauma intervention (Benedek & Fullerton, 2007). Skills for Psychological Recovery (SPR) builds on PFA by adding adaptive skills techniques to reduce ongoing distress and cope with post-trauma adversities (Berkowitz et al., 2010). Cognitive Behavioral Therapy (CBT) is an empirically supported treatment and prevention intervention following trauma (Bryant, 2005). Battlemind Training (BT), a form of cognitive behavioral educational intervention, helps soldiers shift from a reactive combat environment to a garrison and home environment (VA/DoD Clinical Practice Guideline Working Group, 2003) and is effective at reducing post-traumatic stress

symptoms compared with standard post deployment stress education in soldiers with a high number of combat exposures (Adler, Bliese, McGurk, Hoge, & Castro, 2009). Early Combined Collaborative Care (ECCC) is a stepped care early combined intervention that has been found effective at reducing PTSD symptoms in hospitalized trauma survivors (Zatzick et al., 2004, 2013). Stepped care protocols initially engage trauma exposed individuals presenting to “real world” treatment settings with PTSD-neutral intervention strategies that can later be “stepped-up” to evidence-based treatments for individuals with enduring symptoms.

This study examined the effectiveness of TEAM (Troop Education for Army Morale), an early post deployment educational intervention based on the principles of psychological first aid and informed by skills for psychological recovery, cognitive-behavioral therapy, and other evidence-based and evidence-informed interventions. Using a longitudinal randomized control trial design, MA soldiers who received the intervention were compared to MA soldiers who received the usual services offered to soldiers. The impact of TEAM was evaluated on measures of PTSD, depression and perceived quality of life.

Analysis of Data

Manuscript In Preparation

Early Intervention for Traumatic Stress and PTSD in Mortuary Affairs Soldiers

Method

Procedures

Approximately 1 month (mean number of days = 28, $SD = 29.9$; median = 23 days) after returning from deployment to the Middle East, Mortuary Affairs soldiers were given the opportunity to join the TEAM intervention study. They were informed that they would be randomly assigned to either an intervention group receiving the TEAM intervention or a comparison group receiving the usual health care services offered to soldiers. Participation was voluntary. The intervention and comparison groups did not differ in the mean number of days between return from deployment and recruitment (intervention group $M = 29$, $SD = 30.6$; comparison group $M = 27$, $SD = 29.4$; $t(105) = 0.28$, $p = .78$). The study was approved by the Institutional Review Board.

Participants

A total of 126 US Army MA soldiers were recruited in 10 cohorts. Data from all cohorts were grouped for statistical analysis. One intervention group soldier discontinued participation and was not included in the data analysis. Data analysis included 125 participants, 67 in the intervention group and 58 in the comparison group (for a consort diagram, see Figure 1). Nine soldiers who had been in the comparison group enrolled in TEAM for a second time on a subsequent return from deployment and were placed in the intervention group. However, only first enrollments were included in the data analysis (see Appendix A1).

The mean age of the study population (intervention and comparison groups) was 28.1 (range 19-50). There were $N = 85$ (68.0%) males; $N = 40$ (32.0%) females; $N = 72$ (57.6%) were White; $N = 53$ (42.4) were non-white; $N = 56$ (44.8%) had a high school diploma, GED or less and 69 (55.2%) had some college/tech school or more. A total of $N = 78$ (62.4%) were married, $N = 58$ (46.4%) lived with a spouse, $N = 8$ (6.5%) lived with a significant other, and $N = 47$ (43.5%) had children. Regarding military rank, $N = 29$ (23.2%) were E3 or lower, $N = 71$ (56.8%) were E-4, $N = 23$ (18.4%) were E-5 or higher, and $N = 2$ (1.6%) were O-3 or lower. Eighteen soldiers (16.8%) had a spouse or significant other who was active duty military (for a breakdown of demographic characteristics by group, see Table 1). There were no significant differences between groups at baseline, except more soldiers in the intervention group had an active duty military spouse or significant other ($n = 14$) than those in the comparison group ($n = 4$) $\chi^2(1, N = 107) = 4.84, p = .03$ (for a comparison of demographic characteristics by group, see Appendix A2).

TEAM Intervention

The TEAM intervention consisted of interactive group sessions, informational handouts, and a dedicated web site. Four 2-hour sessions were held at approximately 2, 3, 4 and 7 months after return from deployment. The principles of PFA were presented in an educational format with a discussion of the practical application of each principle (for further description, see Appendix B1). An intervention handbook was developed for intervention facilitators to ensure consistent delivery of the intervention (see Appendix B2). PFA-related handouts and healthcare resource information were distributed after recruitment and at the intervention sessions (see Appendix C). Additional intervention content was available on a password-protected website developed specifically for this study (see Appendix D). Participants also had access to a toll-free

phone line and email service for intervention-related communications with the study personnel.

The comparison group received no intervention and only completed assessments at each time point (for a timeline of study activities, see Appendix A3).

Attendance

All participants attended an average of 2.7 (54.0%; median = 3.0, mode = 4.0) of the five intervention or assessment sessions after recruitment (see Appendix A4 for attendance by cohort and group). There was no difference between the average number of intervention or assessment sessions attended by the intervention and comparison groups (intervention group $M = 2.6$, $SD = 1.4$; comparison group $M = 2.8$, $SD = 1.5$; $t(123) = -0.75$, $p = .45$). Attendance decreased over time on average for all participants (68.8% at month 2, 59.2% at month 3, 53.6% at month 4, 47.2% at month 7, and 38.4% at month 10). Of the intervention group, 71.7% attended at least two of the four group intervention sessions (see Appendix A5).

Assessments

Intervention and comparison group participants completed surveys approximately 1, 2, 3, 4, 7 and 10 months post deployment. The month 1 survey (see Appendix E1) was part of another study and TEAM participants gave written permission to use it as the baseline for TEAM. Month 2 through month 10 surveys (see Appendices E2 – E4) were completed by the intervention and comparison groups at the start of each session. For the comparison group, sessions only involved completion of the survey. For the intervention group, intervention activities began after completion of the surveys. At base line, 108 surveys were collected; at month 2, 82 surveys were collected; at month 3, 73; at month 4, 68; at month 7, 60; and at month 10, 48 surveys were collected (for a breakdown of assessments by cohort and group, see Appendix A6).

TEAM Program for Spouses

Married intervention group participants were encouraged to invite their spouse to participate in a TEAM program for spouses. Spouses received spouse-only group intervention sessions and the same handouts, website access, toll-free phone line and email service as the MA soldiers in the intervention group. Participation was voluntary and spouses were not asked to complete assessments. Some intervention group soldiers expressed a reluctance to invite their spouse to the spouse program. In other cases, spouses expressed interest in the program but were unable attend. Two spouses participated in the TEAM program for spouses.

Measures

Post-Traumatic Stress Disorder (PTSD). Probable PTSD was measured with the 17-item PTSD Checklist (PCL-17; Weathers, Litz, Herman, Huska, & Keane, 1993). The PCL-17 is widely used by military and civilian populations to measure PTSD symptoms corresponding to criteria B, C, and D (intrusion, avoidance, and hyperarousal) of PTSD as outlined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV; APA 1994). Respondents complete the question, *How much you have been bothered by each problem in the past month?* with one of the following response choices: 1 = *Not at All*, 2 = *A Little Bit*, 3 = *Moderately*, 4 = *Quite a Bit*, and 5 = *Extremely*. The PCL-17 was scored with a total sum score for symptom severity (Range 17 - 85 with a higher number indicating a greater number or severity of symptoms). Probable PTSD caseness was established using the method developed by Hoge et al. (2004) where if at least one intrusion symptom, three avoidance symptoms, and two hyperarousal symptoms were reported at the level of moderate or higher during the past month and if the PCL-17 symptom severity score was 44 or higher (indicating high levels of subjective distress), it was considered a case. We also calculated summed subscale scores for each of the three types of symptom subscales: intrusion, avoidance, and hyperarousal.

Depression. Probable major depression was assessed using the nine-item Patient Health Questionnaire Depression Scale (PHQ-9) (Kroenke, Spitzer, Williams, 2001; Spitzer, Kroenke, Williams, 1999). The PHQ-9 has been previously used with soldiers exposed to the dead. Respondents indicated how often each of the nine depressive symptoms had bothered them during the previous 2 weeks. Response choices included 1 = *Not at All*, 2 = *Several Days*, 3 = *More than Half the Days*, and 4 = *Nearly Every Day*, which were recoded to a 0 – 3 range prior to analysis. Depression was measured in two ways. A total depression severity score was calculated (range 0 - 27 with a higher number indicating a greater number or severity of symptoms) and a probable depression case was calculated as five or more of the nine symptoms present *More than Half the Days* or *Most Days* in the past two weeks, with one of the symptoms being depressed mood or anhedonia.

Quality of Life. Quality of life was assessed using the World Health Organization Quality of Life Assessment – Brief Version (WHOQOL-BREF) (WHOQOL Group, 1998). The WHOQOL-BREF comprises 26 items, which measure the following broad domains: physical health, psychological health, social relationships, and environment for the past four weeks (WHOQOL user manual, 1998). Responses to each item range from 1 – 5 but response descriptions vary by question (e.g., 1 = *Very Poor*, *Not at all*, *Very Dissatisfied*, or *Never*; 5 = *Very Good*, *An Extreme Amount*, *Very Satisfied*, *Extremely*, *Completely*, or *Always*), and some items are reverse scored. Subscale scores were calculated for the six-item Psychological Health domain (range 6 – 30), eight-item Environment domain (range 8 – 40), and three-item Social Relationships domain (range 3 – 15) with higher scores indicating greater perception of quality of life. Individual item scores for *How would you rate your quality of life?* and *How safe do you feel in your daily life?* (each range 1 – 5) were calculated for overall quality of life and quality of

life-safety, respectively. Lastly, the Physical domain item, *How satisfied are you with your sleep?* was scored individually (range 1 – 5) for quality of life-sleep.

Unit Leadership. Unit leadership was assessed using the three-item General Leadership Quality Scale developed by Vaitkus (1994). Items included (1) *The leaders in this company would lead well in combat*, (2) *I am impressed by the quality of leadership in this company*, and (3) *My chain of command works well*. Responses, on a 5-point scale with descriptive anchors at 1, 3 and 5 (i.e., 1 = *Strongly Disagree*, 3 = *Neutral*, 5 = *Strongly Agree*), were summed to create a *Unit Leadership score* where higher scores indicate better leadership (range 3 – 15).

Deployment Experience. Deployment experience was assessed using an adapted version of the Combat Experiences Scale (CES; Kilgore et al., 2008). The CES is 37-item scale developed to measure combat experiences such as working with the dead, being exposed to IEDs, interacting with civilians in a combat environment, and witnessing accidents and deaths. We used an adapted, 27-item, CES, which asked respondents to indicate whether they have encountered each experience *In the Past 12 Months*, *More Than 1 Year Ago*, or *Never*. As mortuary affairs workers encounter a unique set of combat experiences, we also included two items asking if respondents had to *Move remains on arrival at mortuary* or *Process personal effects* of the deceased while doing mortuary affairs work in the Middle East. Response choices were 1 = *Yes*, 2 = *No*, and 3 = *NA*. The two mortuary specific items were added to the 27-item CES to form the *Deployment and Mortuary Affairs Exposure Scale*.

Health and Functioning. Health and functioning was assessed using multiple measures. Health-related quality of life items were adapted from the Behavioral Risk Factor Surveillance System (BRFSS) Health Status section (Hennessey, Moriarty, Zack, Scherr & Brackbill, 1994). The 4-question BRFSS HRQOL section is a shorter, simpler alternative to the Short Form-12

(SF-12) and Short Form-36 (SF-36), incorporating questions regarding self-perceived health, recent physical and mental health, and recent activity limitation.

Health Care Utilization. Health care utilization was assessed with multiple items that have been used with disaster and rescue worker populations (Fullerton, Ursano, & Wang, 2004). Subjects indicated whether they had received medical care during the past six months by responding *Yes* or *No* to four items: 1) *Annual physical*, 2) *For physical problems*, 3) *For emotional or family problems*, and 4) *Have you felt in need of medical care, but have not obtained any*.

Barriers to Care. Barriers to care was assessed using an adaptation of the Hoge et al. (2004) Perceived Barriers to Seeking Health Care, which was originally used with a military population. Subjects were asked to rate a group of possible concerns that may have affected their decision to receive or not to receive mental health counseling or services during the past month. Response choices were 1 = *Strongly Disagree*, 2 = *Disagree*, 3 = *Neutral*, 4 = *Agree*, or 5 = *Strongly Agree*. Following Hoge et al. (2004), responses of *Agree* and *Strongly Agree* were combined to indicate a positive response.

Health Risk Behavior. Health risk behaviors were assessed using multiple measures of alcohol and tobacco use. The CAGE was used to assess alcohol abuse (Ewing, 1984; Mayfield, McLeod, & Hall, 1974). The CAGE is a standardized measure that has been evaluated in different populations and shows sensitivities ranging from 43 to 94 percent for detecting alcohol abuse. The word CAGE is an acronym for the four questions about alcohol use behavior (*Needed to Cut back, Annoyed anyone, felt Guilty, needed an Eye-opener*). The CAGE is well suited to self-report because it poses four straightforward *Yes* or *No* questions that can be easily answered. A potential drinking problem was indicated by a positive response to two or more of the CAGE

questions. The CAGE has been used with a military population post deployment (Gutierrez, et al., 2006). Changes in Alcohol and Tobacco Use were evaluated with two items previously used in disaster and military populations (Biggs, et al., 2010). The first item asks *In the past MONTH did you change your drinking habits?* and response choices include 1 = *I do not drink*, 2 = *The amount I drank remained the same*, 3 = *I drank more than usual*, 4 = *I drank less than usual*, and 5 = *I had stopped drinking but started again*. The second item poses the same question but inquires about tobacco use with corresponding response choices. The number of alcoholic drinks consumed at one time was assessed by one item from the AUDIT – C (Saunders, Aasland, Babor, de la Fuente & Grant, 1993). The item asks, *How many alcoholic drinks (one 12 oz. beer, one glass of wine, or one cocktail) do you usually drink at one time?* Response choices were 1 = *Never drink alcoholic beverages*, 2 = *1 drink*, 3 = *2 drinks*, 4 = *3-4 drinks*, 5 = *5-6 drinks*, 7 = *More than 8 drinks*.

Spousal Conflict. The Conflict Tactics Scale (CTS) measures self-reported violence toward the spouse and is the most widely used measure of domestic violence in the U.S. (Straus, 1979). The twenty-three CTS items range in severity from mild (e.g., *Gotten something to back up your side of things*) to severe (e.g., *Used a knife or gun on your spouse*). The CTS has been previously used in studies of domestic violence in the Army (Heyman & Neidig, 1999; McCarroll, et al., 2000) and has been well accepted.

TEAM Program Evaluation. Intervention group surveys included additional items that were not on comparison group surveys. Fifteen items inquired about the helpfulness of various aspects of the TEAM program including the TEAM website, handouts, and exercises related to PFA principles (e.g., calming). Response choices were 1 = *Not at All*, 2 = *A Little Bit*, 3 =

Moderately, 4 = *Quite a Bit*, and 5 = *A lot*. One item inquired; *Overall, did you find the TEAM training helpful for you?* Response choices were 1 = *Yes* and 2 = *No*.

Statistical Analyses

All measures were examined by distribution analyses prior to statistical analysis. Where necessary, variables were recoded, categorized, or transformed to assure distributions appropriate for testing. Descriptive statistics and frequency distributions were examined for each variable at each assessment time point for both the intervention and comparison groups.

Preliminary analyses were conducted to test for equivalence among groups at baseline on demographic and outcome measures to ensure the effectiveness of random assignment. At each time point, cross sectional analysis examined the rates of symptom reports and presence or absence of PTSD and the relationship to demographics and exposure comparing soldiers in the intervention and comparison groups. Parametric and nonparametric tests were used as appropriate. The significance level of statistical tests was set at 5% and tests were two-tailed.

Our primary outcome measures for assessment of the effectiveness of TEAM were the PCL-17 symptom severity score, PHQ-9 total score, and WHOQOL psychological and environmental subscale scores. The longitudinal effect of treatment on outcome measures was derived from a linear mixed model using the measure's score as the dependent variable and time (six time points: baseline and five follow-ups), treatment (two groups: treatment and comparison), and the interaction between time and treatment as independent variables. To control for potential confounding effects in estimating the mixed model, we compared various covariate models and selected the model that was the most statistically efficient. Covariates used in the final PCL-17 and WHOQOL models were gender (1 = *Male*, 2 = *Female*), having children (*Do you have children?* 1 = *Yes*, 2 = *No*), and the interaction of treatment and having children.

Covariates in the final PHQ-9 model were gender and unit leadership score (see Appendix A7 for the mixed model covariate comparisons). For analytic convenience, control variables were rescaled to be centered about their means.

The SAS PROC MIXED procedure with repeated measures was used to compute both fixed and random effects and derive the predicted PCL-17 score at each time point (Littell, Milliken, Stroup, Wolfinger, & Schabenberger, 2006). Because intervals between two adjacent time points were unequally spaced in the longitudinal data, the REPEATED/TYPE = SP(POW) option was used in executing the SAS PROC MIXED procedure to represent the autoregressive error structure of the longitudinal data. For analytic simplicity and without loss of generality, between-individuals random effects were not further specified with the presence of a specific residual variance/covariance structure. Statistically, a combination of both error types is often found to fit the data about the same as does a model of either type (Hedeker & Gibbons, 2006). Hence, in the estimation process the variable *time* (months 1, 2, 3, 4, 7 and 10) is treated as a classification factor and one time point is used as a reference. For the PCL-17 and PHQ-9 models, the month 1 time point (baseline) was used as the reference. The WHOQOL was not assessed at month 1, therefore, the last time point (month 10) was used as the reference. The application of SAS PROC MIXED procedure has the added advantage of being robust in handling the missing follow-up data thereby not necessitating the use of the multiple imputation approach (Littell et al., 2006). PC SAS version 9.3 was used to perform statistical analyses.

Whenever possible, statistical analyses were performed with $N = 125$ subjects. The effective sample for analyses that included measures only found on the baseline was $N = 108$ (i.e., 17 participants did not have baseline data) and $N = 96$ when measures found only on later surveys were also included (i.e., 12 participants did not attend activities after baseline).

Results

At baseline, all soldiers ($N = 108$) reported at least one type of exposure on the Deployment and Mortuary Affairs Exposure Scale. Intervention group participants had an average of 7.6 exposures ($SD = 2.5$) and comparison group participants had an average of 7.7 exposures ($SD = 2.6$). There was no significant difference between groups.

Soldiers described their general health as *good* on average at baseline. They report being *moderately* bothered by emotional problems (such as feeling anxious, depressed or irritable) on average in the past three months and reported that personal or emotional problems had *very little* impact on their daily activities. Of the past 30 days, physical health was not good an average of 5.5 days and mental health was not good an average of 8.7 days. Poor physical or mental health kept soldiers from doing daily activities (e.g., self-care, work, recreation) an average of 3.0 days and kept them from going to work an average of 0.3 days. Average hours of sleep per night of the past week was Sunday 6.1, Monday 5.6, Tuesday 5.7, Wednesday 5.7, Thursday 5.7, Friday 6.1, Saturday 7.1, which totals 41.8 hours for the week. Fatigue in the past week was described as *moderate* on average. At work over the past two weeks, soldiers reported that they *lost concentration, repeated a job, worked more slowly than usual, and did nothing at work* an average of *some of the time* but felt fatigued *half of the time*. There were no significant differences between groups on measures of health and functioning.

In the six months prior to baseline, 37.7% of soldiers had an *annual physical*, 41.5% had obtained medical care *for physical problems*, and 26.7% had sought medical care *for emotional or family problems*. Another 29.8% said that in the past six months they *felt in need of medical care, but have not obtained any*. In the past month, Soldiers saw a health care provider an

average of 1.2 times (range 0 - 10). There were no significant differences between groups on measures of health care utilization.

At baseline, consumption of alcohol was reported by 78.8% of soldiers (51.9% drinking one or less times per week and 26.9% drinking two or more times per week). Of those who drink, 39.8% consume three or more drinks at one time and 18.5% consume five or more drinks at one time. In the past three months, 27.1% said they did not drink alcohol, 15.0% drank less than usual, 34.6% drank the same as usual, 15.0% drank more than usual, and 8.4% had stopped drinking but started again. A total of 10.3% said they had *used more alcohol than they meant to* in the last year. On the CAGE alcohol use screener, 5.6% of soldier reported a score of 2 or more indicating a potential drinking problem. There were no significant differences between groups on the alcohol measures.

Daily cigarette smoking was reported by 53.3% of soldiers at baseline. Another 14.3% had previously smoked but quit and 32.4% had never smoked. The most common amount smoked per day was 6 – 10 cigarettes. In the past three months, 13.1% reported decreasing tobacco use, 27.1% used the same amount, 24.3% increased tobacco use, 4.7% had stopped using tobacco but started again, and 30.8% said they did not use tobacco. There were no significant differences between groups on the tobacco measures.

The average number of items endorsed on the 46-item Conflict Tactics Scale was 3.5 (range 0 – 23) at baseline. Of those, 1.8 (range 0 – 11) items pertained to conflict by the soldier and 1.7 (range 0 – 12) items pertained to conflict by the spouse. Soldiers rated their degree of happiness in their marital relationship as *very happy* on average. There were no significant differences between groups.

The concerns that might affect a soldier's decision to receive mental health counseling or services in the past month (i.e., barriers to care), as reported at baseline, are listed in Table 2 from most to least frequently endorsed. The item, *My leadership might treat me differently*, was endorsed by significantly more soldiers in the intervention group ($N = 19$) than in the comparison group ($N = 7$; $\chi^2(1, N = 81) = 4.14, p = .04$). Otherwise, there were no significant differences between groups.

Post Traumatic Stress Disorder

Baseline data on probable cases of PTSD was available for $N = 108$. In total, 27 (25.0%) had probable PTSD, 13 (22.4%) in the intervention group and 14 (28.0%) in the comparison group. There were no significant differences in probable cases of PTSD by group at baseline ($\chi^2(1, N = 108) = 0.45, p = .50$). In addition, the mean PCL-17 total symptom severity score was not significantly different between groups at baseline (intervention group: $M = 34.3, SD = 16.1$; comparison group: $M = 36.2, SD = 16.8$; $t(106) = -0.62, p = .54$).

Participants in the intervention group who lived with a spouse had higher levels of PTSD than participants who did not live with a spouse (spouse: $M = 39.9, SD = 17.2$; no spouse: $M = 30.0, SD = 14.1$) $t(56) = -2.39, p = .02$ and this difference was not present in the comparison group. Similarly, participants in the intervention group who had children had higher levels of PTSD than those who did not have children (children: $M = 40.8, SD = 18.2$; no children: $M = 28.9, SD = 12.1$) $t(42) = -2.86, p = <.01$. This difference also was not present in the comparison group.

Table 3 presents analytic results of the linear mixed model on the PCL total score with the covariates of gender, having children, and the interaction of treatment and having children. The estimates of the random effects are statistically significant. The SP variance/covariance

structure covers a relatively small but statistically meaningful portion of the total variance in this linear mixed model, thus highlighting some intra-individuals correlation along the longitudinal course. The statistical significance of the random effects demonstrates the importance of considering the clustering effect when analyzing longitudinal health data.

In terms of the fixed effects, the intercept displays the population estimate of the PCL total score by those in the comparison group at month 1 (baseline), as the comparison group is coded 0 and month 1 is used as the reference in specification of the two classification factors and the three control variables are centered at sample means. The regression coefficients of the five time variables show a significant effect of time at month 10 $t(276) = -2.10, p = .04$ and a significant time by treatment interaction at month 3 $t(276) = 2.51, p = .01$.

Table 4 presents the Type 3 tests of fixed effects. On their own, the main effects of time and treatment were not significant. However, the time by treatment interaction was significant $F(5, 276) = 2.51, p = .03$ and therefore both main effects are considered statistically meaningful in our analysis (time: $F(5, 276) = 2.07, p = .07$; treatment: $F(1, 103) = 0.01, p = .94$). Of the control variables, higher PCL total scores can be expected for women than men $F(1, 103) = 7.05, p = <.01$ and participants who have children compared to those without children $F(1, 103) = 6.84, p = .01$, other variables being equal.

Table 5 presents two sets of the predicted PCL total scores, one for the treatment group and one for the comparison group, and the results of the local test assessing the statistical significance of the difference between the scores at the six time points. There were no significant differences between scores at any time point.

Figure 2 plots the trajectory of the predicted PCL total score for the treatment and comparison groups with the three control variables centered at sample means, derived from the

above analytic results. The two time trend curves display the time by treatment interaction, which is most evident in the opposed change in trajectories of the two groups at month 3.

Although, as mentioned, there were no significant differences in PCL total scores between groups at any time point.

Intrusion, Avoidance, and Hyperarousal

Like the regression coefficient of the month 3 time by treatment interaction of the PCL total score, the month 3 time by treatment interaction coefficients of the intrusion, avoidance and hyperarousal subscales were all significant (intrusion: $t(276) = 2.20, p = .03$; avoidance: $t(276) = 2.14, p = .03$; hyperarousal: $t(276) = 1.99, p = .04$). The hyperarousal subscale also had a significant time by treatment interaction at month 2 $t(276) = 2.02, p = .04$ and a significant effect of time at month 10 $t(276) = -2.36, p = .02$. The tables and figures of the intrusion, avoidance and hyperarousal subscale mixed models can be found in Appendices A8, A9 and A10, respectively.

For the type 3 fixed effects, there was a significant time by treatment interaction for the intrusion subscale scores $F(5, 276) = 2.44, p = .04$, a marginally significant interaction for the hyperarousal subscale scores $F(5, 276) = 2.11, p = .06$, and no interaction for the avoidance subscale scores $F(5, 276) = 1.47, p = .20$. Because the interaction term of the intrusion subscale is statistically significant, both main effects are considered statistically meaningful (time: $F(5, 276) = 1.71, p = .13$; treatment: $F(1, 103) = 0.05, p = .82$).

PCL scores for females were higher than males on all three PCL subscales: intrusion $F(1, 103) = 6.60, p = .01$, avoidance $F(1, 103) = 7.38, p = <.01$, and hyperarousal $F(1, 103) = 5.15, p = .03$. Similarly, PCL scores for participants who have children were higher than those who do not have children on all three subscales: intrusion $F(1, 103) = 7.70, p = <.01$, avoidance $F(1,$

$F(1, 103) = 5.38, p = .02$, and hyperarousal $F(1, 103) = 5.14, p = .03$. There were no significant differences in local tests of the predicted PCL subscale scores on any of the three subscales at any of the six time points.

Depression

Baseline data on probable cases of depression were available for $N = 106$. In total, 25 (23.6%) had probable depression and 17 (16.0%) had both PTSD and depression. Of the intervention group, 12 (21.4%) had depression and 7 (12.5%) had both PTSD and depression. Of the comparison group, 13 (26.0%) had depression and 10 (20.0%) had both PTSD and depression. There were no significant differences in probable cases of depression by group at baseline $\chi^2(1, N = 106) = 0.31, p = .58$. In addition, the average PHQ-9 total severity score was not significantly different between groups at baseline (intervention: $M = 7.6, SD = 6.9$; comparison: $M = 8.2, SD = 7.4$; $t(104) = -0.44, p = .66$).

Several significant differences in level of depression symptoms were present in the intervention or the comparison groups exclusively. Depression was higher in intervention group participants who were married ($M = 9.3, SD = 7.5$) versus not married ($M = 5.4, SD = 5.6$) $t(54) = 2.15, p = .04$ and in those who had children ($M = 9.8, SD = 8.0$) compared to those without children ($M = 5.8, SD = 5.4$) $t(41) = -2.09, p = .04$. In the comparison group, depression was higher in women ($M = 11.7, SD = 7.1$) than men ($M = 6.7, SD = 7.1$) $t(48) = -2.28, p = .03$ and in those who had some college or more education ($M = 9.8, SD = 7.4$) compared to those with a high school/GED education or less ($M = 5.5, SD = 6.7$) $t(48) = -2.08, p = .04$.

Table 6 presents analytic results of the linear mixed model on the PHQ total score with the covariates of gender and unit leadership score. The estimates of the random effects and SP variance/covariance structure are statistically significant. The regression coefficients of the five

time variables show a significant effect of time at month 7 $t(273) = -2.16, p = .03$ and month 10 $t(273) = -2.31, p = .02$.

The type 3 tests of fixed effects are presented in Table 7. The effect of time is marginally significant $F(5, 273) = 2.25, p = .05$ but there is no effect of treatment or interaction of time by treatment. Of the control variables, women are expected to have higher PCL scores than men $F(1, 104) = 9.40, p = <.01$, and those with higher leadership scores at baseline (i.e., more favorable perception of leadership) have lower PCL scores $F(1, 104) = 18.69, p = <.001$, other variables being equal.

Table 8 presents the predicted PHQ scores and results of the local test assessing the statistical significance of the difference between the scores at the six time points. There were no significant differences in PHQ scores at any time point.

Figure 3 plots the trajectory of the predicted PHQ score for the intervention and comparison groups with the control variables centered at sample means. The two time trend curves show the marginally significant ($p = .05$) change in PCL scores over time for both groups but there are no significant differences between groups at any time point.

Quality of Life

Quality of Life was first assessed at time point 2 (2 months post deployment). There were no significant differences in mean total scores between groups for the WHOQOL psychological subscale (intervention: $M = 21.1, SD = 5.1$; comparison: $M = 22.5, SD = 4.6; t(78) = -1.29, p = .20$) or environmental subscale (intervention: $M = 29.2, SD = 4.9$; comparison: $M = 29.8, SD = 6.2; t(78) = -0.49, p = .62$). Nor were there significant differences in mean scores between groups for the social relationships subscale (intervention: $M = 11.2, SD = 2.7$; comparison: $M = 11.6, SD = 2.8; t(78) = -0.70, p = .49$) or the single items measures of overall quality of life (intervention:

$M = 3.7, SD = 0.9$; comparison: $M = 3.9, SD = 0.7; t(78.7) = -0.99, p = .32$), safety (intervention: $M = 3.8, SD = 0.9$; comparison: $M = 3.9, SD = 1.0; t(78) = -0.75, p = .46$), or sleep (intervention: $M = 2.7, SD = 1.3$; comparison: $M = 2.6, SD = 1.4; t(78) = 0.20, p = .85$).

Women had significantly lower psychological quality of life (indicating worse functioning) compared to men (women: $M = 19.8, SD = 4.5$; men: $M = 22.5, SD = 4.8$) $t(78) = 2.33, p = .02$. In addition, for the intervention group, psychological quality of life was lower in those who were married ($M = 19.1, SD = 5.1$) versus not married ($M = 23.7, SD = 3.9$) $t(43) = 3.33, p = <.01$, lived with a spouse ($M = 18.6, SD = 5.3$) versus did not live with a spouse ($M = 23.2, SD = 3.8$) $t(43) = 3.34, p = <.01$, and in those who had children ($M = 18.9, SD = 5.0$) compared to those who did not have children ($M = 22.9, SD = 4.7$) $t(36) = 2.52, p = .02$. These differences were not present in the comparison group.

Environmental quality of life was lower in intervention group participants who were married ($M = 28.0, SD = 4.1$) versus not married ($M = 30.9, SD = 5.5$) $t(43) = -2.04, p = .047$ and had children ($M = 27.1, SD = 3.6$) compared to those who did not have children ($M = 30.5, SD = 5.3$) $t(36) = 2.27, p = .03$. These differences were not present in the comparison group.

We examined WHOQOL psychological and environmental subscale scores with linear mixed modeling analyses like those of the PCL and PHQ and found no differences. The tables and figures of the WHOQOL psychological and environmental subscale mixed models can be found in Appendix A11 and A12, respectively. The significance values of the type 3 test of fixed effects for the PCL, PHQ and WHOQOL outcome measures are available in Appendix A13.

Evaluation of TEAM

Intervention group participants' last available evaluations of TEAM resources and educational content were compiled. The informational handouts were reported to be *Quite a Bit*

or *A Lot* helpful by 38.3% (see Table 9). However, many participants reported little use of the TEAM website or the phone and email service to investigators. The educational content was reported to be helpful in many areas. For example, 54.7% reported that the TEAM training helped *Quite a Bit* or *A Lot* with *Relaxation techniques* and *Problem solving*. Similarly, 52.9% reported the TEAM training helped *Quite a Bit* or *A Lot* with *Taking care of yourself and managing stress* (for the evaluation results of all training content, see Table 9). Finally, 88.7% of the intervention group responded *Yes* to the question, *Overall, did you find the TEAM training helpful for you?*.

Discussion

The United States has been at war in the Middle East for 13 years, and the psychological tolls of war are well known. Understanding post deployment early interventions is important for service members' recovery and reintegration into the garrison and family environment. MA soldiers are at a high risk for stress-related disorders and no intervention had been developed for this population.

TEAM is the first known post deployment intervention designed for MA soldiers. It is based on the principles of psychological first aid and informed by skills for psychological recovery, cognitive-behavioral therapy and other evidence-based and evidence-informed interventions. TEAM is designed to promote positive adaptation and reduce psychological distress after deployment. TEAM is unique in its early delivery after deployment, small group sessions, and focus on self-care as well as buddy and spouse support.

Our results indicate that the TEAM intervention as presently designed had little effect on PTSD symptoms. There was a time by treatment interaction of the PCL total score that was reflected in changes in intrusion and arousal symptoms. The TEAM intervention showed no

effect on the reduction of depression symptoms or an increase in quality of life with our sample. Mixed modeling local test found no significant differences between groups on any outcome measure at any time point. Several possible factors may have affected intervention efficacy including voluntary attendance, delivery early in the post deployment period, the number and spacing of the sessions and intervention intensity.

The time trend curves at month 3, reflecting the time by treatment interaction, showed an increase in PTSD symptoms for the intervention group and a simultaneous decrease in symptoms for the comparison group. This finding was contrary to our expectation. However, by month 4 the trends reversed. Symptom levels have been found to increase in the months after deployment (Bliese, Wright, Adler, Thomas, & Hoge, 2007) but this effect should have been present in both study groups. Psychological debriefing interventions like CISD have been found to increase symptom levels (Bisson, Jenkins, Alexander, & Bannister, 1997; Mayou, Ehlers, & Hobbs, 2000). The TEAM intervention did not specifically include the retelling of traumatic experiences or expression of emotion, which are thought to be related to symptom increases, and there were no known negative effects of PFA. However, bringing people together in the context of their recent deployment may have fostered storytelling and an increase in symptoms. The reasons behind the time trend curve changes of both groups is unclear and highlights the need to better understand recovery and the course of symptoms after deployment.

We noted the importance of controlling for gender and presence or absence of having children in studying post traumatic stress in military personnel. As is commonly found, PCL scores for females were generally higher than for males. Interestingly, for participants in the intervention group, PCL scores were higher for those who lived with a spouse and/or had children. Since these variables were related, having children, which accounted for more variance,

was included as a covariate in the mixed model of the PCL. Future studies should consider stratification to ensure randomization by presence of children.

Approximately one of every four MA soldiers has probable PTSD or depression, which places them at higher risk for PTSD and depression than combat troops (Hoge et al., 2004) and highlights the need for effective interventions for MA soldiers. Despite the need for mental health care, more MA soldiers sought care for medical or physical problems than emotional or family problems. The most frequently reported barriers to seeking mental health care were related to how the soldier would be seen and treated by their military leadership and unit members and how it would affect their career rather than problems with the cost or efficacy of mental health care. This indicates further efforts are needed to address stigma in the military.

Alcohol and tobacco use are high in the MA population. With approximately one in four soldiers drinking two or more times per week, one in five of those consuming five or more drinks at a time, and more than half of the soldiers smoking tobacco daily, these health risk behaviors carry their own burdens for the soldier, his family and society.

Despite having little effect on PTSD and depression symptoms, the TEAM intervention was feasible and readily accepted by MA soldiers. Most (89%) reported that, overall, the intervention was helpful for them and many of the intervention elements noted as helpful were key elements of psychological first aid (e.g., calming and connecting with and supporting others). Specific elements of the intervention may have been more beneficial for MA soldiers than other elements. Further analysis of the data is needed to determine which parts of TEAM had the greatest impact and on what outcome variables.

Limitations of our study include self-selection for study and attendance, self-report measures, conducting the intervention during work hours, and participation that is dependent

upon Command and job duties. With these limitations in mind, future studies should address several challenges such as better understanding the interaction between having a family and participating in the intervention that result in greater distress. Given the potential effects of having a spouse on PTSD, spousal intervention may benefit the soldier and spouse (Monson et al., 2012).

Future adaptations of TEAM will address ways to increase utilization of the intervention website as well as email and phone support services. Further analyses of data will address the role of outcomes other than PTSD, depression and psychological and environmental quality of life including work function, marital conflict, and barriers to health care utilization. In addition, we will examine the relationships between outcome variables and risk and protective factors such as previous exposures, training, military unit cohesion, and social support.

These findings add to the body of literature regarding post deployment interventions for military personnel. Psychological readjustment after return from deployment is a critical public health concern considering the number of military personnel returning from deployment. Further study of mental health interventions for MA personnel and other war exposed high-risk groups is needed.

Figure 1. Enrollment and participation of the intervention and comparison groups

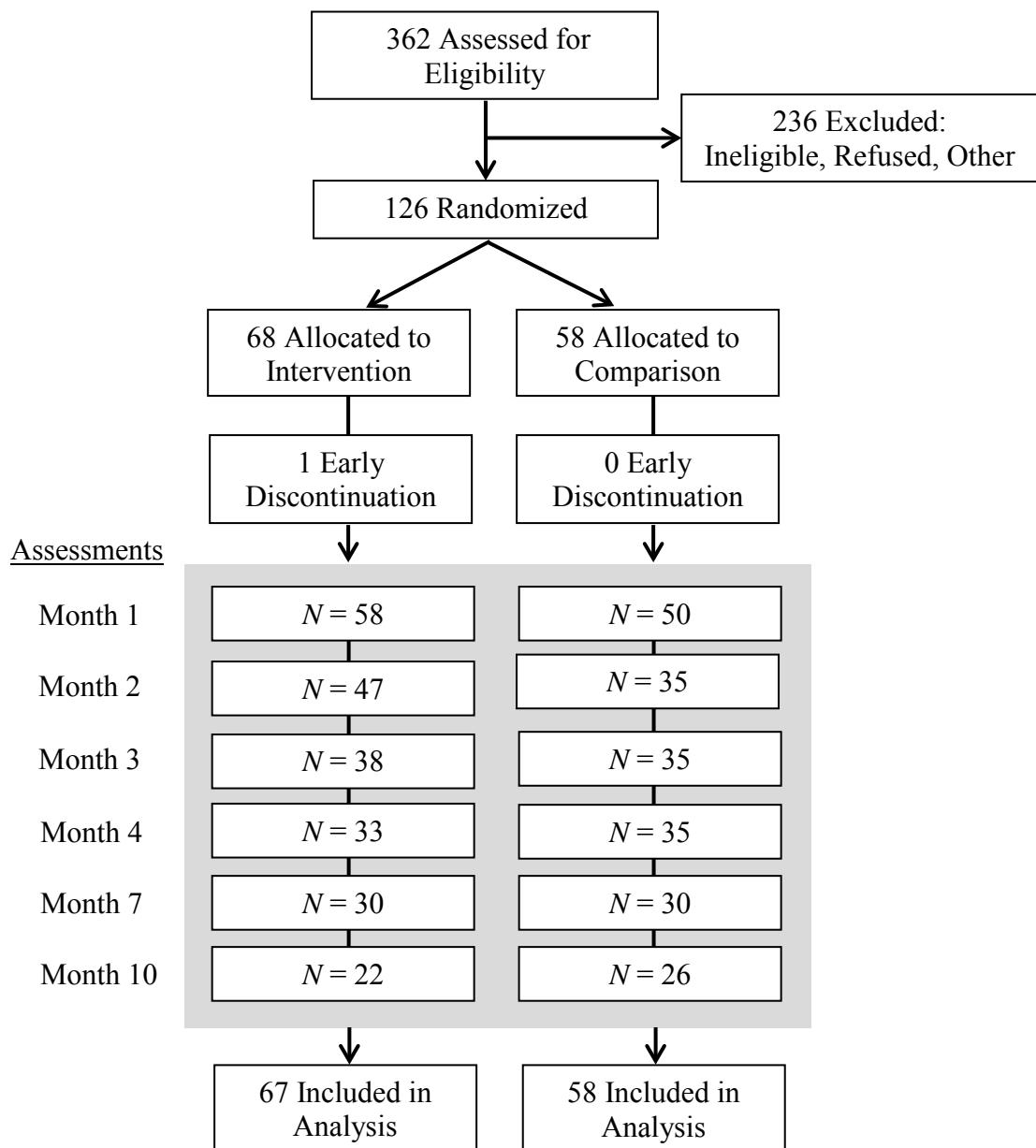


Table 1. Demographic Characteristics of Cohorts 1 - 10

Demographic Characteristic	Total (N = 125)[†]	Intervention (N = 67)	Comparison (N = 58)
	<i>N (%)</i>	<i>N (%)</i>	<i>N (%)</i>
Age			
Mean (SD), years	28.1 (7.2)	28.6 (7.6)	27.6 (6.8)
Range	19-50	19-50	19-50
Male Gender	85 (68.0)	44 (65.7)	41 (70.7)
Race/Ethnicity			
White	72 (57.6)	35 (52.2)	37 (63.8)
Non-White	53 (42.4)	32 (47.8)	21 (36.2)
Education			
High School diploma/GED or less	56 (44.8)	30 (44.8)	26 (44.8)
Some College/Tech School or more	69 (55.2)	37 (55.2)	32 (55.2)
Married	78 (62.4)	38 (56.7)	40 (69.0)
Live with Spouse	58 (46.4)	30 (44.8)	28 (48.3)
Live with Significant Other (N = 124)	8 (6.5)	5 (7.6)	3 (5.2)
Have Children (N = 108)	47 (43.5)	26 (44.8)	21 (42.0)
Rank			
E-3 or lower	29 (23.2)	13 (19.4)	16 (27.6)
E-4	71 (56.8)	39 (58.2)	32 (55.2)
E-5 or higher	23 (18.4)	14 (20.9)	19 (15.5)
0-3 or lower	2 (1.6)	1 (1.5)	1 (1.7)
S/SO Active Duty Military (N = 107)	18 (16.8)*	14 (24.1)	4 (8.2)

^{*}p <.05; ** p <.01; *** p <.001; [†]N = 125 unless specified

Table 2. Barriers to Care Item Response Frequency

Item Response (N = 81 unless noted)	N (%)
There would be difficulty getting time off work for an appointment	28 (34.6)
My leadership might treat me differently	26 (32.1)
I would be seen as weak	21 (25.9)
It would harm my career	16 (19.8)
It is too difficult to schedule an appointment (N = 80)	15 (18.8)
Members of my unit would lose confidence in me	14 (17.3)
My leaders would blame me for the problem	12 (14.8)
I don't trust mental health professionals	12 (14.8)
It would be too embarrassing	11 (13.6)
I don't have adequate transportation	5 (6.2)
I don't know where to get help	4 (4.9)
Mental health care doesn't work	4 (4.9)
Mental health care costs too much money	2 (2.5)

Table 3. Parameter Estimates of the Longitudinal Mixed Model on PCL-17 Total Score with Gender, Have Children, and the Interaction of Treatment & Have Children as Covariates ($N = 108$)

Independent Variable	Estimate	SE	t or z	P
Fixed effects				
Intercept	34.1 ***	2.7	12.74	<.001
Month 1 (reference point)	--	--	--	--
Month 2	-1.0	1.7	-0.57	.57
Month 3	-1.8	2.1	-0.85	.40
Month 4	1.5	2.5	0.59	.55
Month 7	-3.2	3.4	-0.93	.35
Month 10	-7.7 *	3.7	-2.10	.04
Treatment	-3.1	3.7	-0.85	.40
Month 1*treatment	--	--	--	--
Month 2*treatment	3.8	2.2	1.71	.09
Month 3*treatment	7.5 *	3.0	2.51	.01
Month 4*treatment	-0.3	3.6	-0.08	.94
Month 7*treatment	<0.1	4.7	0.01	.99
Month 10*treatment	3.3	5.2	0.63	.53
Female (centered)	7.0 **	2.6	2.66	<.01
Have children (centered)	5.4	3.6	1.52	.13
Interaction of treatment & have children (centered)	1.8	4.9	0.37	.71
Random effects				
Spatial power	0.8 ***	<0.1	31.67	<.001
Residual	244.8 ***	23.8	10.29	<.001
Model chi-square	180.3 ***	--	--	<.001

* $p < .05$; ** $p < .01$; *** $p < .001$; Estimate = parameter estimate, SE = standard error

Table 4. Type 3 Tests of Fixed Effects for PCL-17 Total Score ($N = 108$)

Effect	F	p
Time	2.07	.07
Treatment	0.01	.94
Time*treatment	2.51*	.03
Female (centered)	7.05**	<.01
Have children (centered)	6.84*	.01
Interaction treatment & have children (centered)	0.14	.71

* $p < .05$; ** $p < .01$; *** $p < .001$

Table 5. Predicted Least Squares Means of PCL-17 Total Score and Significance Tests on Differences in Mean for Intervention and Comparison Groups at Six Time Points ($N = 108$)

Time Point	Intervention		Comparison		<i>ED</i>	<i>SE</i>	<i>t</i>	<i>p</i>
	Mean	<i>SE</i>	Mean	<i>SE</i>				
Month 1	34.7	2.1	36.9	2.2	-2.2	3.0	-0.73	.47
Month 2	37.6	2.2	36.0	2.4	1.6	3.3	0.50	.62
Month 3	40.3	2.3	35.1	2.5	5.3	3.4	1.55	.12
Month 4	35.9	2.5	38.4	2.5	-2.5	3.6	-0.69	.49
Month 7	31.6	3.0	33.7	3.0	-2.2	4.2	-0.51	.61
Month 10	30.3	3.3	29.2	3.2	1.1	4.6	0.24	.81

p* <.05; *p* <.01; ****p* <.001; *SE* = standard error; *ED* = estimated difference

Figure 2. Longitudinal Trajectories of PCL-17 Total Score for Intervention and Comparison Groups with Gender, Have Children, and the Interaction of Treatment & Have Children as Covariates ($N = 108$)

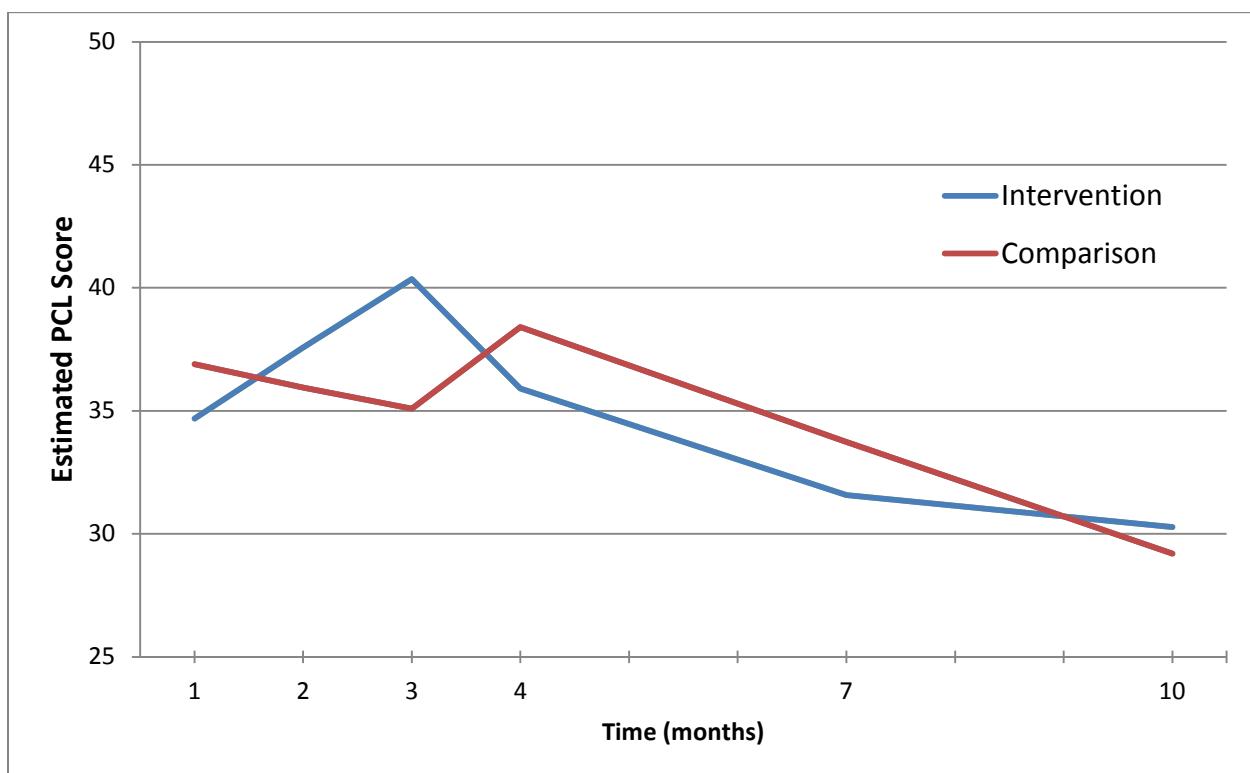


Table 6. Parameter Estimates of the Longitudinal Mixed Model on PHQ-9 Total Score with Gender and Leadership as Covariates (N = 108)

Independent Variable	Estimate	SE	t or z	p
Fixed effects				
Intercept	8.3 ***	0.9	9.44	<.001
Month 1 (reference point)	--	--	--	--
Month 2	-0.7	0.7	-0.89	.37
Month 3	-0.7	0.9	-0.79	.43
Month 4	-1.5	1.1	-1.42	.16
Month 7	-3.0 *	1.4	-2.16	.03
Month 10	-3.5 *	1.5	-2.31	.02
Treatment	-0.9	1.2	-0.75	.45
Month 1*treatment	--	--	--	--
Month 2*treatment	0.7	1.0	0.73	.47
Month 3*treatment	2.1	1.3	1.61	.11
Month 4*treatment	1.6	1.5	1.05	.29
Month 7*treatment	2.1	2.0	1.07	.29
Month 10*treatment	1.4	2.1	0.65	.52
Female (centered)	3.0 **	1.0	3.07	<.01
Leadership (centered)	-0.6 ***	0.1	-4.32	<.001
Random effects				
Spatial power	0.8 ***	<0.1	24.99	<.001
Residual	38.9 ***	3.7	10.63	<.001
Model chi-square	136.9 ***	--	--	<.001

* p <.05; ** p <.01; *** p <.001; Estimate = parameter estimate, SE = standard error

Table 7. Type 3 Tests of Fixed Effects for PHQ-9 Total Score ($N = 108$)

Effect	F	p
Time	2.25	.05
Treatment	0.18	.67
Time*treatment	0.59	.71
Female (centered)	9.40**	<.01
Leadership (centered)	18.69***	<.001

* $p < .05$; ** $p < .01$; *** $p < .001$

Table 8. Predicted Least Squares Means of PHQ-9 Total Score and Significance Tests on Differences in Mean for Intervention and Comparison Groups at Six Time Points ($N = 108$)

Time Point	Intervention		Comparison		<i>ED</i>	<i>SE</i>	<i>t</i>	<i>p</i>
	Mean	<i>SE</i>	Mean	<i>SE</i>				
Month 1	7.5	0.8	8.4	0.9	-0.9	1.2	-0.75	.45
Month 2	7.5	0.9	7.7	1.0	-0.2	1.3	-0.14	.89
Month 3	8.8	0.9	7.6	1.0	1.2	1.4	0.86	.39
Month 4	7.5	1.0	6.8	1.0	0.7	1.5	0.48	.63
Month 7	6.5	1.2	5.3	1.2	1.2	1.7	0.69	.49
Month 10	5.4	1.3	4.9	1.3	0.5	1.8	0.26	.80

* $p < .05$; ** $p < .01$; *** $p < .001$; *SE* = standard error; *ED* = estimated difference

Figure 3. Longitudinal Trajectories of PHQ-9 Total Score for Intervention and Comparison Groups with Gender and Leadership as Covariates ($N = 108$)

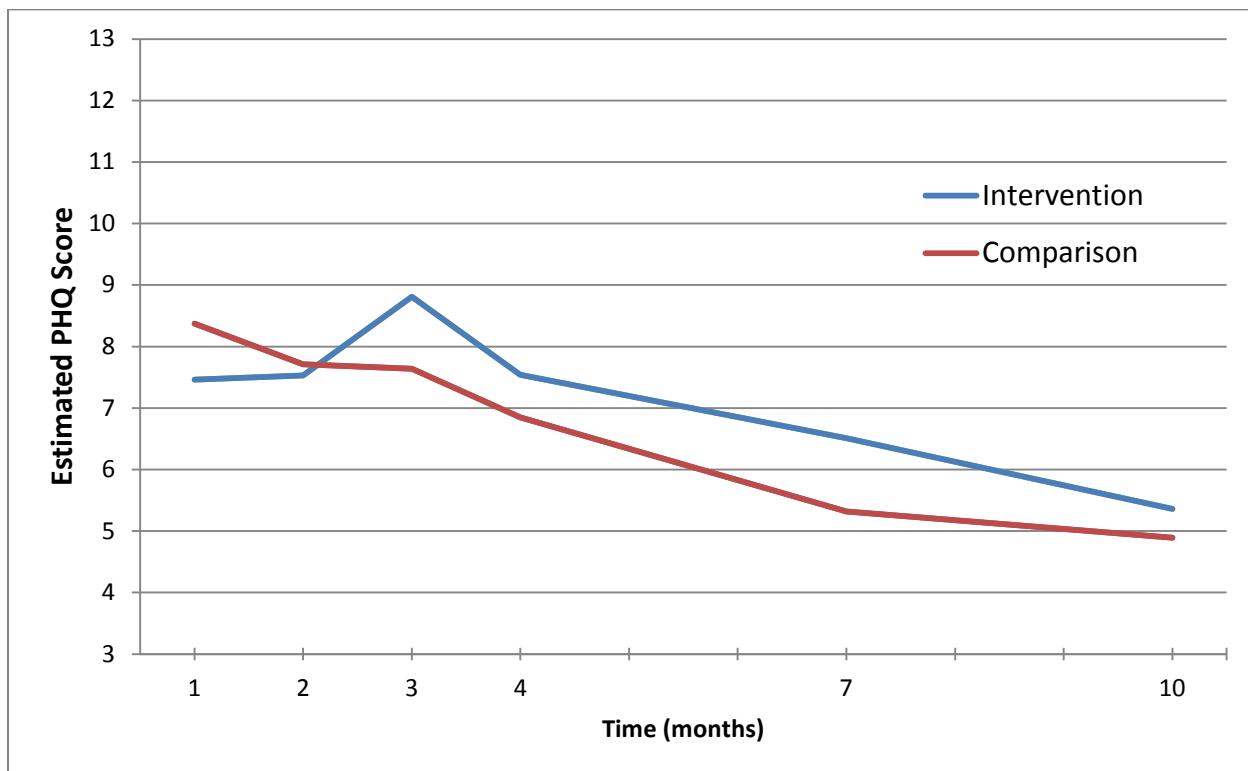


Table 9. TEAM Program Evaluation Item Response Frequencies

TEAM Program Evaluation Item Response Frequencies

Item Stem and Questions	Not at All N (%)	A Little Bit N (%)	Moderately N (%)	Quite A Bit N (%)	A Lot N (%)	N/A N (%)
How Helpful Have the TEAM Resources Been to You (If not used, select N/A): (<i>N</i> = 60)						
Handouts	5 (8.3)	7 (11.7)	11 (18.3)	11 (18.3)	12 (20.0)	14 (23.3)
Website	13 (21.7)	4 (6.7)	10 (16.7)	8 (13.3)	6 (10.0)	19 (31.7)
Phone Line to Investigators	18 (30.0)	6 (10.0)	6 (10.0)	5 (8.3)	3 (5.0)	22 (36.7)
Email to Investigators	16 (26.7)	4 (6.7)	9 (15.0)	8 (13.3)	4 (6.7)	19 (31.7)
How Helpful has the Training Been in: (<i>N</i> = 53)						
Recognizing problems you have been having in re-adjusting to garrison and/or family life	5 (9.4)	5 (9.4)	19 (35.9)	14 (26.4)	10 (18.9)	--
Talking with people about your concerns and problems	4 (7.6)	7 (13.2)	16 (30.1)	16 (30.1)	10 (18.9)	--
Taking care of yourself and managing stress	5 (9.4)	4 (7.6)	16 (30.2)	18 (34.0)	10 (18.9)	--
Making it easier for you to ask for, or seek care	8 (15.1)	5 (9.4)	18 (34.0)	12 (22.6)	10 (18.9)	--
Feeling safe	4 (7.6)	9 (17.0)	15 (28.3)	17 (32.1)	8 (15.1)	--
Relaxation techniques	3 (5.7)	5 (9.4)	16 (30.2g)	16 (30.2)	13 (24.5)	--
Communicating with others	3 (5.7)	2 (3.8)	20 (37.7)	16 (30.2)	12 (22.6)	--
Connecting with others (<i>turning to others for support if needed</i>)	4 (7.6)	4 (7.6)	18 (34.0)	17 (32.1)	10 (18.9)	--
Problem solving	5 (9.4)	5 (9.4)	14 (26.4)	17 (32.1)	12 (22.6)	--
Providing support to buddy	4 (7.6)	4 (7.6)	18 (34.0)	12 (22.6)	15 (28.3)	--
Having a positive outlook on things	4 (7.6)	2 (3.8)	21 (39.6)	11 (20.8)	15 (28.3)	--
Overall Helpfulness (<i>N</i> = 53)						
Overall, did you find the TEAM training helpful to you?	No 6 (11.3%)			Yes 47 (88.7%)		

Key Research Accomplishments

- Developed a multimodal educational intervention program based on Psychological First Aid for mortuary affairs soldiers returning from deployment and their spouses
- Produced an intervention handbook for intervention facilitators
- Produced survey assessments for intervention and comparison groups
- Developed a supportive relationship with Fort Lee Command and Mortuary Affairs units for recruitment of subjects and delivery of the TEAM intervention
- Conducted recruitment and intervention sessions during workday hours in active duty Army companies (i.e., established the feasibility of conducting the TEAM intervention)
- Identified high rates of probable disorder (PTSD and depression), health risk behaviors (alcohol and tobacco use), and barriers to seeking mental health care that contribute to mortuary affairs soldiers' high risk for negative outcomes
- Examined the longitudinal effectiveness of the TEAM intervention on symptoms of PTSD and depression and determined that the TEAM intervention, as currently designed, has little impact on psychiatric disorder
- Evaluation of the TEAM program found that it was well received, soldiers reported the educational content to be helpful in identifiable areas (e.g., calming, connecting with others, problem solving), and most participants (89%) reported that overall, TEAM was helpful for them

Conclusion

Several important findings emerged from this study. Post deployment mortuary affairs (MA) soldiers are at a higher risk for PTSD and depression than combat troops as reported by Hoge et al., 2004. Alcohol and tobacco use are high as are stigma-related barriers to seeking mental health care. The most frequently reported barriers to care were related to a negative perception of how the soldier would be seen and treated by military leadership and unit members if mental health care was sought and how it would negatively affect their career.

The psychological first aid (PFA)-based TEAM intervention was well accepted and most participants reported that it was helpful for them. Specific contents of the intervention that are directly related to PFA (e.g., relaxation techniques, taking care of yourself and managing stress, and communicating with others) were rated as *Quite A Bit* or *A Lot* helpful by more than half of the participants suggesting that soldiers may benefit from PFA-based interventions after deployment.

However, the TEAM intervention as currently designed had little effect on symptoms of PTSD and depression or perceived quality of life. Several possible factors may have affected intervention efficacy including voluntary attendance, delivery in the post deployment period, the number and spacing of the intervention sessions and intervention intensity.

Importantly, it was identified that having a family (e.g., being married, living with a spouse and having children) as well as being female generally increase the risk for PTSD and depression after deployment. These findings may inform the design of future studies and/or screening and interventions for soldiers after deployment.

Early intervention with MA soldiers returning from deployment is feasible through coordination and planning with Command and individual units. Future adaptations of TEAM

will address ways to increase utilization of the intervention website as well as email and phone support services. Further analyses of data will address the role of outcomes other than PTSD, depression and psychological and environmental quality of life including work function, marital conflict, and barriers to health care utilization. In addition, we will examine the relationships between outcome variables and risk and protective factors such as previous exposures, training, military unit cohesion, and social support.

These findings add to the body of literature regarding post deployment interventions for military personnel. Psychological readjustment after return from deployment is a critical public health concern considering the number of military personnel returning from deployment. Further study of mental health interventions for MA personnel and other war exposed high-risk groups is needed.

Publications, Abstracts and Presentations

April, 2009

Early Care for Psychological Trauma: Innovations in Teaching and Delivery

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Abstract

Populations exposed to traumatic events (e.g., war, disaster, terrorism) are at increased risk for posttraumatic distress and adjustment difficulties. It is critical for health care professionals and others who work with trauma-exposed populations to know and apply the current standard of early trauma care. A new educational intervention program based on evidence informed principles of Psychological First Aid (PFA) and Cognitive Behavioral Therapy (CBT) has been developed to address specific post-trauma needs. PFA is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping through five key principles: 1) physical and psychological safety, 2) calming, 3) connectedness, 4) self-efficacy and 5) hope/optimism. CBT is an approach to altering the thoughts and beliefs that lead to negative emotions and has been shown to prevent and treat posttraumatic stress disorder when administered early after trauma exposure. The intervention program involves individual skills training, active engagement in problem solving, exploring barriers to healthcare utilization and building and integrating resources within the home (e.g., spouse support) and occupational environment (e.g., coworker support). Spouses and coworkers can be offered an equivalent intervention program to improve their ability to understand and support the needs of the trauma-exposed individual as well as to meet their own specific needs for support. Participants are trained to 1) develop self-care skills and healthy cognitions, 2) recognize when someone needs care, 3) provide early support to foster rapid recovery and adjustment and 4) recognize barriers to care and promote health care utilization when needed. The intervention is delivered through group workshops, handouts, a website and toll-free phone information line. The impact of this new educational intervention program is being assessed with a group of high risk U.S. Army Mortuary Soldiers upon their return from deployment.

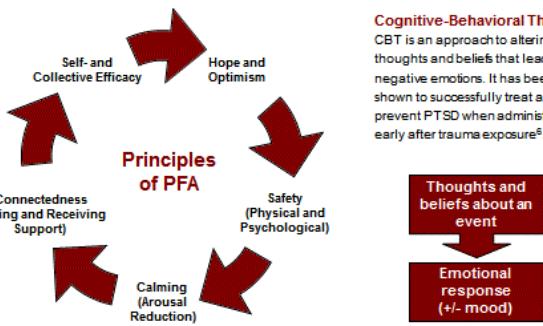


EARLY CARE FOR PSYCHOLOGICAL TRAUMA: INNOVATIONS IN TEACHING AND DELIVERY

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BACKGROUND		METHODS OF DELIVERY							
<p>Exposure to traumatic events such as war, terrorism, natural disasters, motor vehicle collisions and assault can cause considerable psychological distress, psychiatric disorders, impaired functioning and an increase in health risk behaviors (e.g., use of alcohol or tobacco). For example, rates of posttraumatic stress disorder (PTSD), depression and alcohol misuse were as high as 19%, 13% and 30%, respectively, in Soldiers returning from Iraq and Afghanistan¹. Similarly, rates of PTSD and depression were 22% and 13%, respectively, in disaster workers 13 months after responding to an airplane crash². The burden of disease caused by traumatic events can interfere with an individual's ability to function in the work and home environment and affect the family. Often, individuals exposed to trauma do not seek help for their problems³.</p>		 <ul style="list-style-type: none"> Stepped collaborative care model⁷ (increase care as needed) Concierge-type service (be available when help is wanted) Didactic/group workshops Educational handouts Address specific concerns in workshops via index cards Informational website (training materials, resources) Toll-free telephone information line Email service Referral resources Spouse and buddy support 							
NEW EDUCATIONAL INTERVENTION									
<p>A New Educational Intervention Program</p>  <p>Primary Objective: Help trauma exposed individuals increase coping in the initial weeks and months after a traumatic event Specific Aims: Speed recovery, decrease time to return to work, and limit barriers to healthcare utilization Components: Education and individual skills training, active engagement in problem solving and accessing healthcare, and tailoring needs and resources</p> <p>The intervention builds individual self-care skills and skills for supporting others within the individuals unique social context. The program integrates resources within the home and work environment to enhance the natural role of spouse and buddy support. Spouses and buddies are offered an equivalent intervention program including all workshops, resources and self-care and support components. The intervention is unique in that it is based on the evidence informed principles of Psychological First Aid (PFA)³⁻⁵ and Cognitive Behavioral Therapy (CBT). The intervention is education-based and NOT mental or physical health treatment.</p>		<p>Workshop 1 Stress Reactions Safety</p> <p>Workshop 2 Calmness Connectedness</p> <p>Workshop 3 Self-Efficacy Hope/Optimism</p> <p>Booster Review of all prior topics</p>							
TRAINING GOALS									
<p>Training Goals</p> <p>The intervention focuses on the education and training of trauma exposed individuals and their spouses and buddies to:</p> <ul style="list-style-type: none"> Increase adaptive coping in response to symptoms of stress Identify when an individual is in need of care Develop individual self-care skills and healthy cognitions Improve communication skills and build supportive relationships Provide early support to foster rapid recovery Address health risk behaviors (e.g., alcohol, tobacco) Promote health care seeking when needed Overcome barriers to healthcare utilization 									
EVIDENCE INFORMED PRINCIPLES									
<p>Psychological First Aid</p> <p>PFA³⁻⁵ is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping by ensuring the following five principles:</p> <ul style="list-style-type: none"> Safety Calmness Connectedness Self/Collective Efficacy Hope and Optimism  <p>Cognitive-Behavioral Therapy</p> <p>CBT is an approach to altering thoughts and beliefs that lead to negative emotions. It has been shown to successfully treat and prevent PTSD when administered early after trauma exposure⁶.</p>		<p>Thoughts and beliefs about an event</p> <p>Emotional response (+/- mood)</p> <p>Currently, this intervention is being offered to U.S. Army Mortuary Affairs soldiers and their spouses at Fort Lee, VA. Shortly after return from deployment to Iraq and Afghanistan, Soldiers attend an introduction to the intervention. Workshops 1, 2 and 3 follow at 30, 60 and 90 days from return from deployment and the booster takes place at 6 months. Outcomes including rates of posttraumatic distress and disorders, impaired functioning and healthcare utilization are assessed throughout the study.</p>							
SUMMARY									
<ul style="list-style-type: none"> Exposure to traumatic events increases the risk of psychological distress, psychiatric disorders and health risk behaviors A new educational intervention uses evidence informed principles of psychological first aid and cognitive-behavioral therapy as well as a stepped care model of support and a concierge-type service to address recovery from traumatic events The intervention enhances the natural role of spouse and buddy support and addresses barriers to healthcare utilization Interventions of this type are in critical need due to the high number of soldiers returning from Iraq and Afghanistan with psychiatric disorders and the low rate of utilizing needed mental healthcare¹ Principles of the educational intervention are relevant to all branches of the military, disaster workers, first responders and others exposed to high demand and risky environments <p>References:</p> <ol style="list-style-type: none"> Hoge CM et al. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. <i>NJM</i>, 351, 12-22. Burnam OS et al. (2004). Acute stress disorder, posttraumatic stress disorder, and depression in disaster and rescue workers. <i>Am J Psychiatry</i>, 161, 1370-1376. Benedek DM & Fullerton CS (2007). Translating five essential elements into programs and practice. <i>Psychiatry</i>, 70, 348-349. Hodgkiss BE et al. (2007). Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. <i>Psychiatry</i>, 70, 283-315. National Child Traumatic Stress Network and National Center for PTSD. Psychological First Aid: Field Operations Guide, 2nd Ed. 2006. Available: www.nctsnn.org. Bryant RA (2005). Psychosocial approaches to acute stress reactions. <i>CNS Spectrums</i>, 10, 119-122. Zatzick D et al. (2004). A randomized effectiveness trial of stepped collaborative care for acutely injured trauma survivors. <i>Archives of General Psychiatry</i>, 61, 498-506. 									

May, 2009

Early Intervention for Posttraumatic Stress Disorder in Mortuary Affairs Soldiers

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Abstract

U.S. Army Mortuary Affairs Soldiers (MA) returning from Iraq and Afghanistan report high rates of posttraumatic stress disorder (PTSD), psychological distress, personal and family stress, functional impairment and needing but not obtaining health care. A new educational intervention, TEAM (Troop Education for Army Morale), is designed to reduce distress and foster adaptive functioning. TEAM is based on evidence informed principles of Psychological First Aid (safety, calming, connectedness, self-efficacy, hope/optimism) delivered through workshops, handouts, a website and phone line. Soldiers and their spouses learn to use self-care skills, recognize when soldiers need care, provide support (buddy care, spouse support), identify barriers to care and promote health care utilization when needed. MA Soldiers, randomized to TEAM or no intervention, complete questionnaires upon return from deployment and at 1, 2, 3, 6, and 9 months. Significant reductions in arousal, distress and functional impairment as well as increases in healthcare utilization are anticipated. Data are not yet available. Findings will increase our knowledge of PFA based early intervention and PTSD symptomology. Implications include the feasibility of early intervention with all military service members, first responders, disaster workers and others exposed to the dead.



EARLY INTERVENTION FOR POSTTRAUMATIC STRESS DISORDER IN MORTUARY AFFAIRS SOLDIERS

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BACKGROUND	METHODS OF DELIVERY
 <p>U.S. Army Mortuary Affairs Soldiers (MA) returning from Iraq and Afghanistan report high rates of probable posttraumatic stress disorder (PTSD), psychological distress, personal and family stress, functional impairment and needing but not obtaining health care.</p> <ul style="list-style-type: none"> • 19.9% Probable PTSD • 71.6% Moderate to high stress • 57.6% Spouse or significant other experiencing moderate to high stress • 24.6% Seven or more bad mental health days in the past month • 27.7% In need of medical care but did not obtain help 	<p>Methods of Delivery</p> <ul style="list-style-type: none"> • Stepped collaborative care model⁵ (increase care as needed) • Concierge-type service (be available when help is wanted) • Didactic group workshops • Educational handouts • Address specific concerns in workshops via index cards • Informational website (training materials, resources) • Toll-free telephone information line • Email service • Referral resources • Support through spouse and buddy
NEW EDUCATIONAL INTERVENTION	TRAINING GOALS
<p>TEAM (Troop Education for Army Morale): TEAM is a new educational intervention program to help MA Soldiers and their spouses and families reduce distress and foster adaptive coping in the initial weeks and months after return from deployment. TEAM is designed to speed recovery, decrease time to return to work and limit barriers to healthcare utilization. TEAM is currently being offered to Mortuary Affairs soldiers and their spouses at Fort Lee, VA. Components of TEAM include:</p> <ul style="list-style-type: none"> • Building individual self-care skills and skills for supporting others • Integrating resources within the social context of home and unit to enhance the natural role of spouse and buddy support • Education and skills training, active problem solving, engagement in accessing healthcare, and tailoring needs and resources • Offering spouses an equivalent intervention including all workshops, resources and self-care and support components <p>Methods and Evaluation: MA Soldiers, randomized to the TEAM intervention or no intervention, complete questionnaires upon return from deployment and at 1, 2, 3, 6, and 9 months. Probable PTSD, distress, functional impairment, healthcare utilization and utilization of the TEAM program's resources (e.g., website) are assessed. Spouses are not assessed.</p> <p>Assessment of TEAM: Outcomes for Soldiers in the intervention group are compared to the non-intervention group. Significant reductions in arousal, distress and functional impairment as well as increases in healthcare utilization are anticipated. Data are not yet available.</p>	<p>Training Timeline: Shortly after return from deployment, Soldiers attend an introduction to the intervention. Workshops 1, 2 and 3 follow at 30, 60 and 90 days from return from deployment and the booster takes place at 6 months. Outcomes including rates of posttraumatic distress and disorders, impaired functioning and healthcare utilization are assessed throughout the intervention.</p> <p>Training Goals: TEAM focuses on the education and training of Soldiers and their spouses to:</p> <ul style="list-style-type: none"> • Increase adaptive coping in response to symptoms of stress • Identify when an individual is in need of care • Develop individual self-care skills and healthy cognitions • Improve communication skills and build supportive relationships • Provide early support to foster rapid recovery • Address health risk behaviors (e.g., use of alcohol or tobacco) • Promote health care seeking when needed • Overcome barriers to healthcare utilization 
EVIDENCE INFORMED PRINCIPLES	SUMMARY
<p>Basis of the Intervention: TEAM is based on the evidence informed principles of Psychological First Aid (PFA)^{1,3} and Cognitive Behavioral Therapy (CBT)⁴. TEAM is education-based and NOT mental or physical health treatment.</p> <p>Psychological First Aid:</p> <p>PFA is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping by ensuring the following five principles:</p> <ul style="list-style-type: none"> • Safety • Calming • Connectedness • Self/Collective Efficacy • Hope and Optimism <p>Principles of PFA</p> <pre> graph TD P1[Connectedness Giving and Receiving Support] --> P2[Calming Arousal Reduction] P2 --> P3[Self-and Collective Efficacy] P3 --> P4[Hope and Optimism] P4 --> P5[Safety Physical and Psychological] P5 --> P6[Thoughts and beliefs about an event] P6 --> P7[Emotional response +/ mood] </pre> <p>Cognitive-Behavioral Therapy:</p> <p>CBT is an approach to altering thoughts and beliefs that lead to negative emotions. It has been shown to successfully treat and prevent PTSD when administered early after trauma exposure.</p>	<ul style="list-style-type: none"> ◆ Mortuary Affairs Soldiers returning from deployment have high rates risk of psychological distress and adjustment difficulties ◆ TEAM, a new educational intervention uses evidence informed principles of PFA and CBT therapy as well as a stepped care model of support and a concierge-type service to address recovery and adaptation ◆ The intervention enhances the natural role of spouse and buddy support and addresses barriers to healthcare utilization ◆ Interventions of this type are in critical need due to the high number of soldiers returning from Iraq and Afghanistan with psychiatric disorders and the low utilization rate of needed mental healthcare⁶ ◆ Findings will increase our knowledge of PFA based early intervention and PTSD symptomology ◆ Principles of the TEAM intervention are relevant to other branches of the military, first responders, disaster workers and others exposed to the dead <p>References:</p> <ol style="list-style-type: none"> 1 Benedek DM & Fullerton CS (2007). Translating five essential elements into programs and practice. <i>Psychiatry</i>, 70, 345-349. 2 Hoge CW et al. (2007). Five essential elements of immediate and mid-term mass trauma interventions: Empirical evidence. <i>Psychiatry</i>, 70, 283-315. 3 National Child Traumatic Stress Network and National Center for PTSD. <i>Psychological First Aid Field Operations Guide</i>, 2nd Ed. 2006. Available: www.nctsn.org. 4 Bryant RA (2005). Psychosocial approaches to acute stress reactions. <i>CNS Spectrums</i>, 10, 116-122. 5 Zatzick D et al. (2004). A randomized effectiveness trial of stepped collaborative care for acutely injured trauma survivors. <i>Archives of General Psychiatry</i>, 61, 498-506. 6 Hoge CW et al. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. <i>New England Journal of Medicine</i>, 351, 13-22.

June, 2009

Early Care for Psychological Trauma: Innovations in Teaching and Delivery

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Participants are trained to 1) develop self-care skills and healthy cognitions, 2) recognize when someone needs care, 3) provide early support to foster rapid recovery and adjustment and 4) recognize barriers to care and promote health care utilization when needed. The intervention is delivered through group workshops, handouts, a website and toll-free phone information line. The impact of this new educational intervention program is being assessed with a group of high risk U.S. Army Mortuary Soldiers upon their return from deployment.

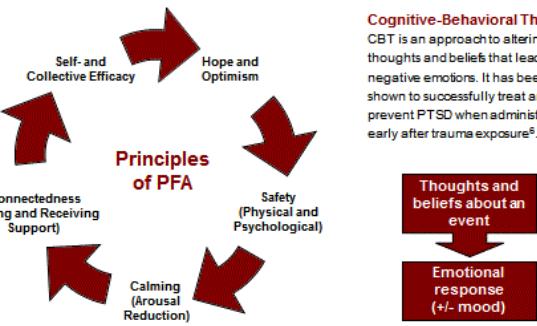


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BACKGROUND	METHODS OF DELIVERY
<p>Exposure to traumatic events such as war, terrorism, natural disasters, motor vehicle collisions and assault can cause considerable psychological distress, psychiatric disorders, impaired functioning and an increase in health risk behaviors (e.g., use of alcohol or tobacco). For example, rates of posttraumatic stress disorder (PTSD), depression and alcohol misuse were as high as 19%, 13% and 30%, respectively, in Soldiers returning from Iraq and Afghanistan¹. Similarly, rates of PTSD and depression were 22% and 13%, respectively, in disaster workers 13 months after responding to an airplane crash². The burden of disease caused by traumatic events can interfere with an individual's ability to function in the work and home environment and affect the family. Often, individuals exposed to trauma do not seek help for their problems³.</p> 	<p>Methods of Delivery</p> <ul style="list-style-type: none"> Stepped collaborative care model⁷ (increase care as needed) Concierge-type service (be available when help is wanted) Didactic group workshops Educational handouts Address specific concerns in workshops via index cards Informational website (training materials, resources) Toll-free telephone information line Email service Referral resources Spouse and coworker support <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> Workshop 1 Stress Reactions Safety </div> <div style="text-align: center;"> Workshop 2 Calming Connectedness </div> <div style="text-align: center;"> Workshop 3 Self-Efficacy Hope/Optimism </div> <div style="text-align: center;"> Booster Review of all prior topics </div> </div>
NEW EDUCATIONAL INTERVENTION	TRAINING GOALS
<p>A New Educational Intervention Program</p>  <p>Primary Objective: Help trauma exposed individuals increase coping in the initial weeks and months after a traumatic event Specific Aims: Speed recovery, decrease time to return to work, and limit barriers to healthcare utilization Components: Education and individual skills training, active engagement in problem solving and accessing healthcare, and tailoring needs and resources</p> <p>The intervention builds individual self-care skills and skills for supporting others within the individuals unique social context. The program integrates resources within the home and work environments to enhance the natural role of spouse and coworker support. Spouses and coworkers are offered an equivalent intervention program including all workshops, resources and self-care and support components. The intervention is unique in that it is based on the evidence informed principles of Psychological First Aid (PFA)³⁻⁵ and Cognitive Behavioral Therapy (CBT). The intervention is education-based and NOT mental or physical health treatment.</p>	<p>Training Goals</p> <p>The intervention focuses on the education and training of trauma exposed individuals and their spouses and coworkers to:</p> <ul style="list-style-type: none"> Increase adaptive coping in response to symptoms of stress Identify when an individual is in need of care Develop individual self-care skills and healthy cognitions Improve communication skills and build supportive relationships Provide early support to foster rapid recovery Address health risk behaviors (e.g., use of alcohol or tobacco) Promote health care seeking when needed Overcome barriers to healthcare utilization  <p>The intervention will be piloted with U.S. Army Mortuary Affairs soldiers at Fort Lee, VA and their spouses. Shortly after return from deployment, soldiers attend an introduction and are randomized to workshop or usual services (control) groups. Workshops 1, 2 and 3 follow at 30, 60 and 90 days and the booster at 180 days. Questionnaire assessments will be conducted at 30, 60, 90, 180 and 270 days. Workshop and usual services groups will be compared on outcomes including rates of posttraumatic stress and disorders, impaired functioning, healthcare utilization and utilization of program services (e.g., website, email, telephone info line).</p>
EVIDENCE INFORMED PRINCIPLES	SUMMARY
<p>Psychological First Aid</p> <p>PFA³⁻⁵ is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping by ensuring the following five principles:</p> <ul style="list-style-type: none"> Safety Calm Connectedness Self/Collective Efficacy Hope and Optimism  <p>Cognitive-Behavioral Therapy</p> <p>CBT is an approach to altering thoughts and beliefs that lead to negative emotions. It has been shown to successfully treat and prevent PTSD when administered early after trauma exposure⁶.</p>	<p>❖ Exposure to traumatic events increases the risk of psychological distress, psychiatric disorders and health risk behaviors</p> <p>❖ A new educational intervention uses evidence informed principles of psychological first aid and cognitive-behavioral therapy as well as a stepped care model of support and a concierge-type service to address recovery from traumatic events</p> <p>❖ The intervention enhances the natural role of spouse and coworker support and addresses barriers to healthcare utilization</p> <p>❖ Interventions of this type are in critical need due to the high number of soldiers returning from Iraq and Afghanistan with psychiatric disorders and the low rate of utilizing needed mental healthcare¹</p> <p>❖ Principles of the educational intervention are relevant to all branches of the military, disaster workers, first responders and others exposed to high demand and risky environments</p> <p>References:</p> <ol style="list-style-type: none"> Biggs CM et al. (2004). Combat duty in Iraq and Afghanistan: mental health problems and barriers to care. <i>NEJM</i>, 351, 13-22. Fullerton CS et al. (2004). Acute stress disorder, posttraumatic stress disorder, and depression in disaster or rescue workers. <i>Am J Psychiatry</i>, 161, 1370-1376. Benedek DM & Fullerton CS (2007). Translating five essential elements into programs and practice. <i>Psychiatry</i>, 70, 349-349. Hobfoll SE et al. (2007). Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. <i>Psychiatry</i>, 70, 282-315. National Child Traumatic Stress Network and National Center for PTSD. Psychological First Aid: Field Operations Guide, 2nd Ed. 2006. Available: www.nctsn.org. Bryant RA (2005). Psychosocial approaches to acute stress reactions. <i>CNS Spectrums</i>, 10, 116-122. Zatzick D et al. (2004). A randomized effectiveness trial of stepped collaborative care for acutely injured trauma survivors. <i>Archives of General Psychiatry</i>, 61, 498-506.

September, 2009

Mortuary Affairs Soldiers: Early Intervention and Altering Barriers to Care for Traumatic Stress and PTSD

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Abstract

Background and Objectives

U.S. Army Mortuary Affairs Soldiers (MA) returning from Iraq and Afghanistan have substantial rates of Posttraumatic Stress Disorder (PTSD), depression, psychological distress and health risk behaviors (e.g., alcohol or tobacco use). Exposure to death and combat increases the risk for posttraumatic distress and adjustment difficulties. After deployment, MA Soldiers report high rates of personal and family stress, functional impairment and needing but not obtaining health care. Support from family, co-workers and supervisors has been found to be beneficial in the weeks and months post-deployment. A newly developed educational intervention, TEAM (Troop Education for Army Morale), is designed to address specific post-deployment needs of MA soldiers. TEAM involves individual skills training, active engagement in problem solving, exploring barriers to healthcare utilization and building and integrating resources within the unit (e.g., buddy care) and home (e.g., spouse support). TEAM is based on the evidence informed principles of Psychological First Aid (PFA) and Cognitive Behavioral Therapy (CBT). PFA is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping through key principles: 1) physical and psychological safety, 2) calming, 3) connectedness, 4) self-efficacy and 5) hope/optimism. CBT is an approach to altering the thoughts and beliefs that lead to negative emotions and can prevent and treat PTSD when administered early after trauma exposure. Spouses of soldiers participating in TEAM are offered an equivalent intervention tailored to the specific needs of spouses. Soldiers and spouses are trained to 1) develop self-care skills and healthy cognitions, 2) recognize when a soldier needs care, 3) provide early support to foster rapid recovery and adjustment and 4) recognize barriers to care and promote health care utilization when needed. The intervention is delivered through group workshops, handouts, a website and toll-free phone information line.

Methods

TEAM is a longitudinal, randomized controlled trial. MA Soldiers are recruited from the 54th and 111th MA companies at Ft Lee, VA (estimated N=480) within 2 weeks of return from deployment. Questionnaire assessments are conducted at 1, 2, 3, 6, and 9 months post deployment. TEAM participants are compared to MA soldiers not receiving the TEAM intervention. Study goals include demonstrating the feasibility of TEAM for care and support of MA soldiers. Primary outcomes include assessing psychiatric disorder (e.g., PTSD, depression), psychological distress, health risk behaviors, quality of life, work function, marital conflict and barriers to health care utilization.

Results/Conclusions

Not yet available.

Impact Statement

This study has implications for development, assessment and feasibility of early intervention with MA soldiers post-deployment. Our findings will increase our knowledge of resilience and the contribution of soldier education and the environment (i.e., spouse and buddy care) to recovery and adjustment post-deployment. Our study has broader implications for intervention with first responders and other disaster workers exposed to the dead. Findings from this study and principles of the TEAM intervention are relevant to all branches of the military and the community that must sustain first responders in high stress environments including deployments and disasters.



MORTUARY AFFAIRS SOLDIERS: EARLY INTERVENTION AND ALTERING BARRIERS TO CARE FOR TRAUMATIC STRESS AND PTSD

Carol S. Fullerton, Ph.D.¹, Robert J. Ursano, M.D.¹, David M. Benedek, M.D.¹, James McCarroll, Ph.D., M.P.H.¹, Quinn M. Biggs, Ph.D., M.P.H.¹,
Douglas F. Zatzick, M.D.², John H. Newby, Ph.D., M.S.W.¹, Tzu-Cheg Kao, Ph.D.¹, Heather M. Karpel, B.A.¹ **

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BACKGROUND	METHODS OF DELIVERY
 <p>U.S. Army Mortuary Affairs Soldiers (MA) returning from Iraq and Afghanistan have substantial rates of posttraumatic stress disorder (PTSD), depression, psychological distress, and health risk behaviors (e.g., alcohol or tobacco use). Exposure to death and combat increases the risk for posttraumatic distress and adjustment difficulties. After deployment, MA Soldiers report highrates of personal and family stress, functional impairment and needing but not obtaining health care. Support from family, co-workers and supervisors has been found to be beneficial after deployment.</p>	<p>Methods of Delivery</p> <ul style="list-style-type: none"> Stepped collaborative care model⁵ (increase care as needed) Concierge-type service (be available when help is wanted) Didactic/group workshops Educational handouts Address specific concerns in workshops via index cards Informational website (training materials, resources) Toll-free telephone information line Email service Referral resources Support through spouse and buddy
<h3>NEW EDUCATIONAL INTERVENTION</h3> <p>TEAM (Troop Education for Army Morale): TEAM is a new educational intervention program to help MA Soldiers and their spouses and families reduce distress and foster adaptive coping in the initial weeks and months after deployment. TEAM is designed to speed recovery, decrease time to return to work and limit barriers to healthcare utilization. TEAM components include:</p> <ul style="list-style-type: none"> Building individual self-care skills and skills for supporting others Integrating resources within the social context of home and unit to enhance the natural role of spouse and buddy support Education and skills training, active problem solving, engagement in accessing healthcare, and tailoring needs and resources Offering spouses an equivalent intervention including all workshops, resources and self-care and support components <p>Methods and Assessment: TEAM is currently being offered to MA Soldiers (estimated N=480) and their spouses at Fort Lee, VA. MA Soldiers, randomized to the TEAM intervention or no intervention, complete questionnaires upon return from deployment at 1, 2, 3, 6, and 9 months. Primary outcomes include assessing psychiatric disorder (e.g., PTSD, depression), psychological distress, health risk behaviors, quality of life, work function, marital conflict and barriers to healthcare utilization. Participants' use of the TEAM program's resources (e.g., website, phone line) are also assessed. Spouses are not assessed.</p> <p>Evaluation of the TEAM program: Outcomes for Soldiers in the intervention group are compared to the non-intervention group. Study goals include demonstrating the feasibility of TEAM for care and support of MA Soldiers. Significant reductions in arousal, distress and functional impairment as well as increases in healthcare utilization are anticipated. Data are not yet available.</p>	<p>Workshop 1 Stress Reactions Safety</p> <p>Workshop 2 Calmness Connectedness</p> <p>Workshop 3 Self-Efficacy Hope/Optimism</p> <p>Booster Review of all prior topics</p> <p>Training Timeline: Shortly after return from deployment, Soldiers attend an introduction to the intervention. Workshops 1, 2 and 3 follow at 30, 60 and 90 days from return from deployment and the booster takes place at 6 months. Outcomes including rates of posttraumatic distress and disorders, work function and healthcare utilization are assessed throughout the intervention.</p>
<h3>EVIDENCE INFORMED PRINCIPLES</h3> <p>Basis of the Intervention: TEAM is based on the evidence informed principles of Psychological First Aid (PFA)¹⁻³ and Cognitive Behavioral Therapy (CBT)⁴. TEAM is education-based and NOT mental or physical health treatment.</p> <p>Psychological First Aid: PFA is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping by ensuring the following five principles:</p> <ul style="list-style-type: none"> Safety Calming Connectedness Self/Collective Efficacy Hope and Optimism <p>Principles of PFA</p> <pre> graph TD PFA[Principles of PFA] --> SelfEfficacy[Self-and Collective Efficacy] PFA --> Connectedness[Connectedness (Giving and Receiving Support)] PFA --> SafetyPhysical[Safety (Physical and Psychological)] PFA --> CalmingReduction[Calming (Arousal Reduction)] SelfEfficacy --> HopeOptimism[Hope and Optimism] Connectedness --> SafetyPhysical SafetyPhysical --> EmotionalResponse[Thoughts and beliefs about an event --> Emotional response (+/- mood)] CalmingReduction --> EmotionalResponse </pre> <p>Cognitive-Behavioral Therapy: CBT is an approach to altering thoughts and beliefs that lead to negative emotions. It has been shown to successfully treat and prevent PTSD when administered early after trauma exposure.</p>	<p>Training Goals: TEAM focuses on the education and training of Soldiers and their spouses to:</p> <ul style="list-style-type: none"> Increase adaptive coping in response to symptoms of stress Identify when an individual is in need of care Develop individual self-care skills and healthy cognitions Improve communication skills and build supportive relationships Provide early support to foster rapid recovery Address health risk behaviors (e.g., use of alcohol or tobacco) Promote health care seeking when needed Overcome barriers to healthcare utilization 
	<p>♦ Mortuary Affairs Soldiers returning from deployment have high rates of psychological distress and adjustment difficulties</p> <p>♦ TEAM, a new educational intervention, uses evidence informed principles of PFA and CBT therapy as well as a stepped care model of support and a concierge-type service to address recovery and adaptation</p> <p>♦ The intervention enhances the natural role of spouse and buddy support and addresses barriers to healthcare utilization</p> <p>♦ Interventions of this type are in critical need due to the high number of soldiers returning from Iraq and Afghanistan with psychiatric disorders and the low utilization rate of needed mental health care⁶</p> <p>♦ Findings will increase our knowledge of PFA-based early intervention and PTSD symptomology</p> <p>♦ Principles of the TEAM intervention are relevant to other branches of the military, first responders, disaster workers and others exposed to the dead</p> <p>** We wish to acknowledge additional members of our Intervention Team: LCDR Patcho Santiago, M.D., M.P.H., Christine Gray, M.P.H., Stephanie N. Riley, B.S., and Natalie T. Kodsy, M.A.</p> <p>References:</p> <ol style="list-style-type: none"> Benedek DM & Fullerton CS (2007). Translating the essential elements into programs and practice. <i>Psychiatry</i>, 70, 246-249. Hobfoll SE et al. (2007). Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. <i>Psychiatry</i>, 70, 283-315. National Child Traumatic Stress Network and National Center for PTSD. <i>Psychological First Aid: Field Operations Guide</i>, 2nd Ed. 2006. Available: www.nctsn.org. Bryant RA (2005). Psychosocial approaches to acute stress reactions. <i>CNS Spectrums</i>, 10, 116-122. Zatzick D et al. (2004). A randomized effectiveness trial of stepped collaborative care for acutely injured trauma survivors. <i>Archives of General Psychiatry</i>, 61, 498-506. Hoge CW et al. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. <i>New England Journal of Medicine</i>, 351, 19-22. <p>Funded by U.S. Army Medical Research & Materiel Command. Congressionally Directed Medical Research Program Award W81XWH-05-2-0100</p>

November, 2009

Early Intervention for Posttraumatic Stress Disorder in Mortuary Affairs Soldiers

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Abstract

U.S. Army Mortuary Affairs Soldiers (MA) returning from Iraq and Afghanistan report high rates of posttraumatic stress disorder (PTSD), psychological distress, personal and family stress, functional impairment and needing but not obtaining health care. A new educational intervention, TEAM (Troop Education for Army Morale), is designed to reduce distress and foster adaptive functioning. TEAM is based on evidence informed principles of Psychological First Aid (safety, calming, connectedness, self-efficacy, hope/optimism) delivered through workshops, handouts, a website and phone line. Soldiers and their spouses learn to use self-care skills, recognize when soldiers need care, provide support (buddy care, spouse support), identify barriers to care and promote health care utilization when needed. MA Soldiers, randomized to TEAM or no intervention, complete questionnaires upon return from deployment and at 1, 2, 3, 6, and 9 months. We present preliminary data on the impact of TEAM to specific PTSD criteria, work function and health care utilization. Significant reductions in arousal, distress and functional impairment are anticipated. Findings will increase our knowledge of PFA based early intervention and PTSD symptomology. Implications include the feasibility of early intervention with all military service members, first responders, disaster workers and others exposed to the dead.



EARLY INTERVENTION FOR POSTTRAUMATIC STRESS DISORDER IN MORTUARY AFFAIRS SOLDIERS

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BACKGROUND	DELIVERY AND TIMELINE																				
 <p>U.S. Army Mortuary Affairs Soldiers (MA) returning from Iraq and Afghanistan have substantial rates of posttraumatic stress disorder (PTSD), depression, psychological distress, and health risk behaviors (e.g., alcohol or tobacco use). Exposure to death and combat increases the risk for posttraumatic distress and adjustment difficulties. After deployment, MA Soldiers report high rates of personal and family stress, functional impairment and need but not obtaining health care. Support from family, co-workers and supervisors has been found to be beneficial after deployment.</p>	<p>Methods of Delivery:</p> <ul style="list-style-type: none"> Stepped collaborative care model⁵ (increase care as needed) Concierge-type service (be available when help is wanted) Didactic/group workshops Educational handouts Informational website (training materials, resources) Toll-free phone information line and email service Referral resources Support through spouse and buddy <div style="display: flex; justify-content: space-around;"> <div style="text-align: center;"> Workshop 1 Stress Reactions Safety (1 mo. post-deploy) </div> <div style="text-align: center;"> Workshop 2 Calming Connectedness (2 mo. p.d.) </div> <div style="text-align: center;"> Workshop 3 Self-Efficacy Hope/Optimism (3 mo. p.d.) </div> <div style="text-align: center;"> Booster Review of all prior topics (6 mo. p.d.) </div> </div>																				
NEW EDUCATIONAL INTERVENTION	PRELIMINARY RESULTS																				
<p>TEAM (Troop Education for Army Morale): TEAM is a new education and skills training intervention to help MA Soldiers and their spouses and families reduce distress and foster adaptive coping in the initial weeks and months after deployment. TEAM training includes building skills for self-care and support of others (e.g., buddy care), active problem solving, engagement in accessing healthcare, and tailoring needs and resources. TEAM integrates resources in the social context of home and unit to enhance the natural role of spouse and buddy support (i.e., spouses are offered an equivalent intervention and all training support).</p> <p>Methods and Assessment: TEAM is currently being offered to MA Soldiers (estimated N=480) and their spouses at Fort Lee, VA. MA Soldiers, randomized to the TEAM intervention or no intervention, complete questionnaires upon return from deployment and at 1, 2, 3, 6, and 9 months. Primary outcomes include assessing psychiatric disorder (e.g., PTSD, depression), psychological distress, health risk behaviors, quality of life, work function, marital conflict and barriers to healthcare utilization. Participants' use of the TEAM program's resources (e.g., website, phone line) are also assessed. Spouses are not assessed.</p> <p>Goals: The training of Soldiers and spouses to:</p> <ul style="list-style-type: none"> Develop self-care skills and healthy cognitions Increase adaptive coping in response to stress Identify when an individual is in need of care Provide early support to foster rapid recovery 	<p>Assessments: All Soldiers reported that "Overall, the TEAM training was helpful" (N=11). Talking with others (fellow Soldiers), learning about stress and coping, relaxation training, and the educational handouts were among the most helpful components.</p> <p>How much has the TEAM training helped you in...?</p> <p>□ "Not at All" or "A Little Bit" ■ "Moderately" ▨ "Quite A Bit" or "A Lot"</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%;">...recognizing problems re-adjusting post-deployment</td> <td style="width: 30%;">8% (Not at All)</td> <td style="width: 30%;">58% (A Little Bit)</td> <td style="width: 35%;">66% (Quite A Bit or A Lot)</td> </tr> <tr> <td>...talking with people about concerns and problems</td> <td>27%</td> <td>27%</td> <td>48%</td> </tr> <tr> <td>...feeling safe [Safety]</td> <td>8%</td> <td>58%</td> <td>66%</td> </tr> <tr> <td>...using relaxation techniques [Calming]</td> <td>9%</td> <td>18%</td> <td>73%</td> </tr> <tr> <td>...connecting with others [Connectedness]</td> <td>9%</td> <td>27%</td> <td>64%</td> </tr> </table> <p>Observations: Soldiers show interest in participating in TEAM (e.g., a Soldier came in to participate in TEAM during his leave; another requested to continue in TEAM after her separation from the Army). Anecdotal feedback has been positive (i.e., "The [calming exercise] helped me and my family by reducing my anger"). Command at Fort Lee has been very supportive of TEAM.</p>	...recognizing problems re-adjusting post-deployment	8% (Not at All)	58% (A Little Bit)	66% (Quite A Bit or A Lot)	...talking with people about concerns and problems	27%	27%	48%	...feeling safe [Safety]	8%	58%	66%	...using relaxation techniques [Calming]	9%	18%	73%	...connecting with others [Connectedness]	9%	27%	64%
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EVIDENCE INFORMED PRINCIPLES	SUMMARY AND IMPACT																				
<p>Basis of the Intervention: TEAM is based on the evidence informed principles of Psychological First Aid (PFA)¹⁻³ and Cognitive Behavioral Therapy (CBT)⁴. TEAM is education-based and NOT mental or physical health treatment.</p> <p>Psychological First Aid:</p> <p>PFA is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping by ensuring the following five principles:</p> <ul style="list-style-type: none"> Safety Calming Connectedness Self/Collective Efficacy Hope and Optimism 	<p>Cognitive-Behavioral Therapy: CBT is an approach to altering thoughts and beliefs that lead to negative emotions. It has been shown to successfully treat and prevent PTSD when administered early after trauma exposure.</p> <p>Principles of PFA</p> <p>Self-and Collective-Efficacy → Hope and Optimism</p> <p>Connectedness (Giving and Receiving Support) → Safety (Physical and Psychological)</p> <p>Calming (Arousal Reduction) → Thoughts and beliefs about an event</p> <p>Thoughts and beliefs about an event → Emotional response (+/- mood)</p> <p>Summary and Impact:</p> <ul style="list-style-type: none"> Mortuary Affairs Soldiers returning from deployment have high rates of psychological distress and adjustment difficulties TEAM, a new educational intervention, uses evidence informed principles of PFA and CBT therapy as well as a stepped care model of support and a concierge-type service to address recovery and post-deployment adaptation The intervention enhances the natural role of spouse and buddy support and addresses barriers to healthcare utilization Interventions of this type are in critical need due to the high number of soldiers returning from Iraq and Afghanistan with psychiatric disorders and the low utilization rate of needed mental health care⁶ Findings will increase our knowledge of PFA-based early intervention and PTSD symptomology Principles of the TEAM intervention are relevant to other branches of the military, first responders, disaster workers and others exposed to the dead <p>** We wish to acknowledge additional members of our Intervention Team: LCDR Patcho Santiago, M.D., M.P.H., Christine Gray, M.P.H., Stephanie N. Riley, B.S., and Natalie T. Kodsy, M.A.</p> <p>References:</p> <ol style="list-style-type: none"> Biggs QM & Fullerton CS (2007). Translating the essential elements into programs and practice. <i>Psychiatry</i>, 70, 345-349. Horrell SE et al. (2007). Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. <i>Psychiatry</i>, 70, 283-315. National Child Traumatic Stress Network and National Center for PTSD. <i>Psychological First Aid: Field Operations Guide</i>, 2nd Ed. 2006. Available: www.nctsnn.org. Bryant RA (2005). Psychosocial approaches to acute stress reactions. <i>CNS Spectrums</i>, 10, 116-122. Zatzick D et al. (2004). A randomized effectiveness trial of stepped collaborative care for acutely injured trauma survivors. <i>Archives of General Psychiatry</i>, 61, 498-506. Hoge CW et al. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. <i>New England Journal of Medicine</i>, 351, 19-22. <p>Funded by U.S. Army Medical Research & Materiel Command. Congressionally Directed Medical Research Program Award W01XWH-06-2-0150</p>																				

April, 2010

**Early Educational Intervention for Mortuary Affairs Soldiers Post Deployment:
Preliminary Results**

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Abstract

U.S. Army Mortuary Affairs Soldiers (MA) returning from Iraq and Afghanistan report high rates of posttraumatic stress disorder (PTSD), psychological distress, personal and family stress, functional impairment and needing but not obtaining health care. A new educational intervention, TEAM (Troop Education for Army Morale), is designed to reduce distress and foster adaptive functioning. TEAM is based on evidence informed principles of Psychological First Aid (safety, calming, connectedness, self-efficacy, hope/optimism) delivered through workshops, handouts, a website and phone line. Soldiers and their spouses learn to use self-care skills, recognize when soldiers need care, provide support (buddy care, spouse support), identify obstacles to seeking care and promote health care utilization when needed. MA Soldiers, randomized to TEAM or no intervention, complete questionnaires upon return from deployment and at 1, 2, 3, 6, and 9 months. We present preliminary data on TEAM's impact on feelings of safety, use of calming techniques, and Soldiers ability to recognize problems and seek help. Findings from this study will increase our knowledge of PFA based early intervention. Implications include the feasibility of early intervention with all military service members, first responders, disaster workers and others exposed to the dead.



EARLY EDUCATIONAL INTERVENTION FOR MORTUARY AFFAIRS SOLDIERS POST DEPLOYMENT: PRELIMINARY RESULTS

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BACKGROUND



U.S. Army Mortuary Affairs Soldiers (MA) returning from Iraq and Afghanistan have substantial rates of posttraumatic stress disorder (PTSD), depression, psychological distress, and health risk behaviors (e.g., alcohol or tobacco use). Exposure to death and combat increases the risk for posttraumatic distress and adjustment difficulties. After deployment, MA Soldiers report highrates of personal and family stress, functional impairment and needing but not obtaining health care. Support from family, co-workers and supervisors has been found to be beneficial after deployment.

NEW EDUCATIONAL INTERVENTION

TEAM (Troop Education for Army Morale): TEAM is a new education and skills training intervention to help MA Soldiers and their spouses reduce distress and foster adaptive coping in the initial weeks and months after deployment. TEAM training includes building skills for self-care and support of others (e.g., buddy care), active problem solving, engagement in accessing healthcare, and tailoring needs and resources. TEAM integrates resources in the social context of home and unit to enhance the natural role of spouse and buddy support (i.e., spouses are offered an equivalent intervention and all training support).

Methods and Assessment: TEAM is currently being offered to MA Soldiers (estimated N=480) and their spouses at Fort Lee, VA. MA Soldiers, randomized to the TEAM intervention or no intervention, complete questionnaires upon return from deployment at 1, 2, 3, 6, and 9 months. Primary outcomes include assessing psychiatric disorder (e.g., PTSD, depression), psychological distress, health risk behaviors, quality of life, work function, marital conflict and barriers to healthcare utilization. Participants' use of the TEAM program's resources (e.g., website, phone line) are also assessed. Spouses are not assessed.

Goals: The training of Soldiers and spouses to:

- Develop self-care skills and healthy cognitions
- Increase adaptive coping in response to stress
- Identify when an individual is in need of care
- Provide early support to foster rapid recovery



- Build supportive relationships
- Improve communication skills
- Promote health care seeking when needed
- Overcome barriers to healthcare utilization
- Address healthrisk behaviors (e.g., alcohol use)

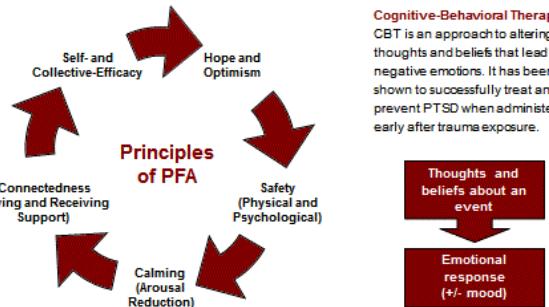
EVIDENCE INFORMED PRINCIPLES

Basis of the Intervention: TEAM is based on the evidence informed principles of Psychological First Aid (PFA)^{1,3} and Cognitive Behavioral Therapy (CBT)⁴. TEAM is education-based and NOT mental or physical health treatment.

Psychological First Aid:

PFA is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping by ensuring the following five principles:

- Safety
- Calming
- Connectedness
- Self/Collective Efficacy
- Hope and Optimism



Cognitive-Behavioral Therapy: CBT is an approach to altering thoughts and beliefs that lead to negative emotions. It has been shown to successfully treat and prevent PTSD when administered early after trauma exposure.

DELIVERY AND TIMELINE

Methods of Delivery:

- Stepped collaborative care model⁵ (increase care as needed)
- Concierge-type service (be available when help is wanted)
- Didactic/group workshops
- Educational handouts
- Informational website (training materials, resources)
- Toll-free phone information line and email service
- Referral resources
- Support through spouse and buddy

Workshop 1
Stress Reactions
Safety
(1 mo. post-deploy)

Workshop 2
Calming
Connectedness
(2 mo. p.d.)

Workshop 3
Self-Efficacy
Hope/Optimism
(3 mo. p.d.)

Booster
Review of all
prior topics
(6 mo. p.d.)

PRELIMINARY RESULTS

Assessments: All Soldiers reported that "Overall, the TEAM training was helpful" (N=11). Talking with others (fellow Soldiers), learning about stress and coping, relaxation training, and the educational handouts were among the most helpful components.

How much has the TEAM training helped you in...

...recognizing problems re-adjusting post-deployment

■ "Not at All" or "A Little Bit" ■ "Moderately" ■ "Quite A Bit" or "A Lot"



...talking with people about concerns and problems



...feeling safe [Safety]



...using relaxation techniques [Calming]



...connecting with others [Connectedness]



Observations: Soldiers show interest in participating in TEAM (e.g., a Soldier came in to participate in TEAM during his leave; another requested to continue in TEAM after her separation from the Army). Anecdotal feedback has been positive (i.e., "The [calming exercise] helped me and my family by reducing my anger"). Command at Fort Lee has been very supportive of TEAM.

SUMMARY AND IMPACT

- ❖ Mortuary Affairs Soldiers returning from deployment have high rates of psychological distress and adjustment difficulties
- ❖ TEAM, a new educational intervention, uses evidence informed principles of PFA and CBT therapy as well as a stepped care model of support and a concierge-type service to address recovery and post-deployment adaptation
- ❖ The intervention enhances the natural role of spouse and buddy support and addresses barriers to healthcare utilization
- ❖ Interventions of this type are in critical need due to the high number of soldiers returning from Iraq and Afghanistan with psychiatric disorders and the low utilization rate of needed mental health care⁶
- ❖ Findings will increase our knowledge of PFA-based early intervention and PTSD symptomology
- ❖ Principles of the TEAM intervention are relevant to other branches of the military, first responders, disaster workers and others exposed to the dead

** Research Team included: John H. Newby, Ph.D., M.S.W., David M. Benedek, M.D., Natalie T. Kodsy, M.A., and Stephanie N. Riley, B.S.

References:

- 1 Benedek DM & Fullerton CB (2007). Translating five essential elements into programs and practice. *Psychiatry*, 70, 345-349.
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- 3 National Child Traumatic Stress Network and National Center for PTSD. *Psychological First Aid: Field Operations Guide*, 2nd Ed. 2008. Available: www.nctsn.org.
- 4 Resick D et al. (2004). A randomized effectiveness trial of stepped collaborative care for acute injured trauma survivors. *Archives of General Psychiatry*, 61, 498-506.
- 5 Hoge CW et al. (2004). Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care. *New England Journal of Medicine*, 351, 15-22.
- 6 Funded by U.S. Army Medical Research & Materiel Command. Congressionally Directed Medical Research Program Award W81XWH-05-2-0150

May, 2010

Early educational intervention for Mortuary Affairs Soldiers post deployment: preliminary results

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Abstract

U.S. Army Mortuary Affairs Soldiers (MA) returning from Iraq and Afghanistan report high rates of posttraumatic stress disorder (PTSD), psychological distress, personal and family stress, functional impairment and needing but not obtaining health care. A new educational intervention, TEAM (Troop Education for Army Morale), is designed to reduce distress and foster adaptive functioning. TEAM is based on evidence informed principles of Psychological First Aid (safety, calming, connectedness, self-efficacy, hope/optimism) delivered through workshops, handouts, a website and phone line. Soldiers and their spouses learn to use self-care skills, recognize when soldiers need care, provide support (buddy care, spouse support), identify obstacles to seeking care and promote health care utilization when needed. MA Soldiers, randomized to TEAM or no intervention, complete questionnaires upon return from deployment and at 1, 2, 3, 6, and 9 months. We present preliminary data on TEAM's impact on feelings of safety, use of calming techniques, and Soldiers ability to recognize problems and seek help. Findings from this study will increase our knowledge of PFA based early intervention. Implications include the feasibility of early intervention with all military service members, first responders, disaster workers and others exposed to the dead.



EARLY EDUCATIONAL INTERVENTION FOR MORTUARY AFFAIRS SOLDIERS POST DEPLOYMENT: PRELIMINARY RESULTS

Quinn M. Biggs, Ph.D., M.P.H., Carol S. Fullerton, Ph.D., James McCarroll, Ph.D., M.P.H.,
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BACKGROUND



U.S. Army Mortuary Affairs Soldiers (MA) returning from Iraq and Afghanistan have substantial rates of posttraumatic stress disorder (PTSD), depression, psychological distress, and health risk behaviors (e.g., alcohol or tobacco use). Exposure to death and combat increases the risk for posttraumatic distress and adjustment difficulties. After deployment, MA Soldiers report highrates of personal and family stress, functional impairment and needing but not obtaining health care. Support from family, co-workers and supervisors has been found to be beneficial after deployment.

NEW EDUCATIONAL INTERVENTION

TEAM (Troop Education for Army Morale): TEAM is a new education and skills training intervention to help MA Soldiers and their spouses and families reduce distress and foster adaptive coping in the initial weeks and months after deployment. TEAM training includes building skills for self-care and support of others (e.g., buddy care), active problem solving, engagement in accessing healthcare, and tailoring needs and resources. TEAM integrates resources in the social context of home and unit to enhance the natural role of spouse and buddy support (i.e., spouses are offered an equivalent intervention and all training support).

Methods and Assessment: TEAM is currently being offered to MA Soldiers (estimated N=480) and their spouses at Fort Lee, VA. MA Soldiers, randomized to the TEAM intervention or no intervention, complete questionnaires upon return from deployment and at 1, 2, 3, 6, and 9 months. Primary outcomes include assessing psychiatric disorder (e.g., PTSD, depression), psychological distress, health risk behaviors, quality of life, work function, marital conflict and barriers to healthcare utilization. Participants' use of the TEAM program's resources (e.g., website, phone line) are also assessed. Spouses are not assessed.

Goals: The training of Soldiers and spouses to:

- Develop self-care skills and healthy cognitions
- Increase adaptive coping in response to stress
- Identify when an individual is in need of care
- Provide early support to foster rapid recovery



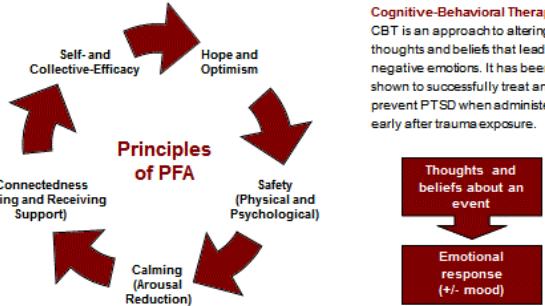
- Build supportive relationships
- Improve communication skills
- Promote health care seeking when needed
- Overcome barriers to healthcare utilization
- Address health risk behaviors (e.g., alcohol use)

EVIDENCE INFORMED PRINCIPLES

Basis of the Intervention: TEAM is based on the evidence informed principles of Psychological First Aid (PFA)¹⁻³ and Cognitive Behavioral Therapy (CBT)⁴. TEAM is education-based and NOT mental or physical health treatment.

Psychological First Aid: PFA is designed to reduce the initial distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping by ensuring the following five principles:

- Safety
- Calming
- Connectedness
- Self/Collective Efficacy
- Hope and Optimism



Cognitive-Behavioral Therapy: CBT is an approach to altering thoughts and beliefs that lead to negative emotions. It has been shown to successfully treat and prevent PTSD when administered early after trauma exposure.

DELIVERY AND TIMELINE

Methods of Delivery:

- Stepped collaborative care model⁵ (increase care as needed)
- Concierge-type service (be available when help is wanted)
- Didactic/group workshops
- Educational handouts
- Informational website (training materials, resources)
- Toll-free phone information line and email service
- Referral resources
- Support through spouse and buddy

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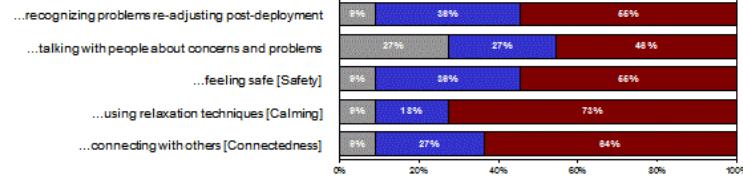
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PRELIMINARY RESULTS

Assessments: All Soldiers reported that "Overall, the TEAM training was helpful" (N=11). Talking with others (fellow Soldiers), learning about stress and coping, relaxation training, and the educational handouts were among the most helpful components.

How much has the TEAM training helped you in...



Observations: Soldiers show interest in participating in TEAM (e.g., a Soldier came in to participate in TEAM during his leave; another requested to continue in TEAM after her separation from the Army). Anecdotal feedback has been positive (i.e., "The [calming exercise] helped me and my family by reducing my anger"). Command at Fort Lee has been very supportive of TEAM.

SUMMARY AND IMPACT

- ❖ Mortuary Affairs Soldiers returning from deployment have high rates of psychological distress and adjustment difficulties
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- ❖ Findings will increase our knowledge of PFA-based early intervention and PTSD symptomology
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Funded by U.S. Army Medical Research & Materiel Command. Congressionally Directed Medical Research Program Award W81XWH-05-2-0150

November, 2010

TEAM: an early educational intervention for Mortuary Affairs Soldiers post deployment; preliminary results from the first three cohorts.

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Abstract

U.S. Army Mortuary Affairs Soldiers (MA) returning from Iraq and Afghanistan report high rates of posttraumatic stress disorder (PTSD), psychological distress, personal and family stress, functional impairment and needing but not obtaining health care. A new educational intervention, TEAM (Troop Education for Army Morale), is designed to reduce distress and foster adaptive functioning. TEAM is based on evidence informed principles of Psychological First Aid (safety, calming, connectedness, self-efficacy, hope/optimism) delivered through workshops, handouts, a website and phone line. Soldiers and their spouses learn to use self-care skills, recognize when soldiers need care, provide support (buddy care, spouse support), identify barriers to care and promote health care utilization when needed. MA Soldiers, randomized to TEAM or no intervention, complete questionnaires upon return from deployment and at 1, 2, 3, 6, and 9 months. We present data on TEAM's impact in the first year including disorder (probable PTSD, depression), functional impairment, ability to recognize problems and seek help (social support, healthcare utilization), safety, arousal and use of calming techniques. Findings will increase our knowledge of PFA based early interventions. Implications include the feasibility of early intervention with all military service members, first responders, disaster workers and others exposed to the dead.

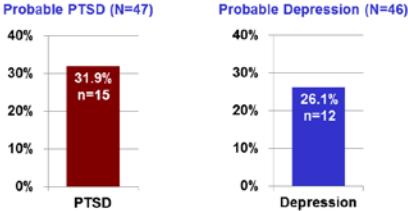
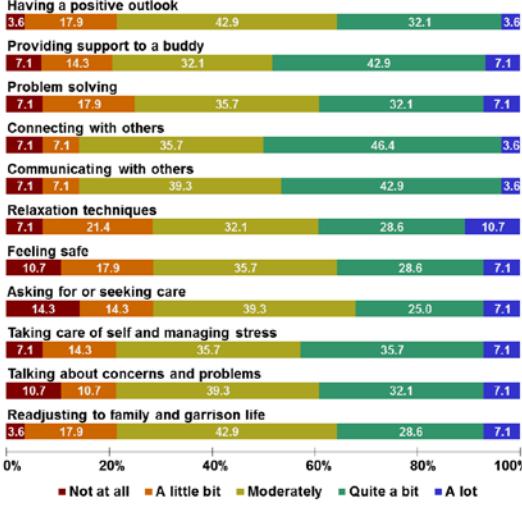


TEAM: AN EARLY EDUCATIONAL INTERVENTION FOR MORTUARY AFFAIRS SOLDIERS POST DEPLOYMENT; PRELIMINARY RESULTS FROM THE FIRST THREE COHORTS

Quinn M. Biggs, Ph.D., M.P.H., Carol S. Fullerton, Ph.D., James McCarroll, Ph.D., M.P.H., Christine Gray, M.P.H., LCDR Patcho Santiago, M.D., M.P.H., John H. Newby, Ph.D., M.S.W., David M. Benedek, M.D., Natalie T. Kodsys, M.A., Stephanie N. Riley, B.S., Chad A. Spiegel, M.A., and Robert J. Ursino, M.D.

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BACKGROUND		PRELIMINARY RESULTS																																																																									
 <p>U.S. Army Mortuary Affairs Soldiers (MA) recover, identify, and evacuate the remains of deceased military personnel and their personal effects from Iraq and Afghanistan. Exposure to death and the combat environment increases the risk for posttraumatic distress and adjustment difficulties.</p>		PTSD and Depression (1 month post deployment)																																																																									
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Delivery of Intervention: <ul style="list-style-type: none"> • Interactive group workshops • Educational handouts • Toll-free phone line and email service • Website (resources, training materials) • Referral resources • Concierge-type service • Stepped collaborative care model⁵ • Support through spouse and buddy 		 <table border="1"> <thead> <tr> <th>Dimension</th> <th>Not at all</th> <th>A little bit</th> <th>Moderately</th> <th>Quite a bit</th> <th>A lot</th> </tr> </thead> <tbody> <tr> <td>Having a positive outlook</td> <td>3.6</td> <td>17.9</td> <td>42.9</td> <td>32.1</td> <td>3.6</td> </tr> <tr> <td>Providing support to a buddy</td> <td>7.1</td> <td>14.3</td> <td>32.1</td> <td>42.9</td> <td>7.1</td> </tr> <tr> <td>Problem solving</td> <td>7.1</td> <td>17.9</td> <td>35.7</td> <td>32.1</td> <td>7.1</td> </tr> <tr> <td>Connecting with others</td> <td>7.1</td> <td>7.1</td> <td>35.7</td> <td>46.4</td> <td>3.6</td> </tr> <tr> <td>Communicating with others</td> <td>7.1</td> <td>7.1</td> <td>39.3</td> <td>42.9</td> <td>3.6</td> </tr> <tr> <td>Relaxation techniques</td> <td>7.1</td> <td>21.4</td> <td>32.1</td> <td>28.6</td> <td>10.7</td> </tr> <tr> <td>Feeling safe</td> <td>10.7</td> <td>17.9</td> <td>35.7</td> <td>28.6</td> <td>7.1</td> </tr> <tr> <td>Asking for or seeking care</td> <td>14.3</td> <td>14.3</td> <td>39.3</td> <td>25.0</td> <td>7.1</td> </tr> <tr> <td>Taking care of self and managing stress</td> <td>7.1</td> <td>14.3</td> <td>35.7</td> <td>35.7</td> <td>7.1</td> </tr> <tr> <td>Talking about concerns and problems</td> <td>10.7</td> <td>10.7</td> <td>39.3</td> <td>32.1</td> <td>7.1</td> </tr> <tr> <td>Readjusting to family and garrison life</td> <td>3.6</td> <td>17.9</td> <td>42.9</td> <td>28.6</td> <td>7.1</td> </tr> </tbody> </table>		Dimension	Not at all	A little bit	Moderately	Quite a bit	A lot	Having a positive outlook	3.6	17.9	42.9	32.1	3.6	Providing support to a buddy	7.1	14.3	32.1	42.9	7.1	Problem solving	7.1	17.9	35.7	32.1	7.1	Connecting with others	7.1	7.1	35.7	46.4	3.6	Communicating with others	7.1	7.1	39.3	42.9	3.6	Relaxation techniques	7.1	21.4	32.1	28.6	10.7	Feeling safe	10.7	17.9	35.7	28.6	7.1	Asking for or seeking care	14.3	14.3	39.3	25.0	7.1	Taking care of self and managing stress	7.1	14.3	35.7	35.7	7.1	Talking about concerns and problems	10.7	10.7	39.3	32.1	7.1	Readjusting to family and garrison life	3.6	17.9	42.9	28.6	7.1
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<ul style="list-style-type: none"> • Gender: 73.1% male; 26.9% female • Age: range 19-50 years (M=28.58) • Education: 1.5% <HS; 43.3% HS/GED; 50.7% some college; 4.5% bachelors • Rank: 16.4% Private or Private First Class; 65.7% Specialist or Corporal; 17.9% Sergeant (all enlisted) • Race: 63.6% White; 16.7% Black; 12.1% Hispanic; 4.5% American Indian or Alaskan Native; 3.0% Asian or Pacific Islander • Marital Status: 68.7% married; years M=4.76; 73.3% live with their spouse 																																																																											
Measures: <ul style="list-style-type: none"> • Probable PTSD: PTSD Checklist (PCL-17): "How much you have been bothered by each problem in the past month" (1="not at all" to 5="extremely"). Probable PTSD if total symptom score ≥ 50 (range 17-85) and 1 intrusion, 3 avoidance, 2 hyperarousal symptoms scored moderately or higher. • Probable Depression: Patient Health Questionnaire (PHQ-9): Positive if 5 or more of 9 symptoms present "more than half the days" or "most days" in the past 2 weeks and at least 1 symptom is depressed mood or anhedonia. 																																																																											
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<ul style="list-style-type: none"> ❖ These preliminary data suggest Mortuary Affairs Soldiers returning from Iraq and Afghanistan have high rates of PTSD and depression. ❖ Most participants described TEAM as being "Moderately" or "Quite a bit" helpful. ❖ TEAM enhances the natural role of spouse and buddy support and addresses barriers to health care utilization. ❖ Interventions of this type are needed due to the high number of Soldiers returning from Iraq and Afghanistan with psychiatric disorders and the low rates of mental health care utilization⁶. ❖ Soldiers returning from deployment report benefit from Psychological First Aid and Cognitive Behavioral Therapy-based early educational intervention. ❖ These findings have implications for the feasibility of this intervention with Soldiers in other branches of the military, first responders, disaster workers and others exposed to the dead. 																																																																											
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April, 2011

Troop Educational for Army Morale (TEAM) post deployment early educational program for Mortuary Affairs Soldiers; results from the first year.

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U.S. Army Mortuary Affairs Soldiers (MA) returning from Iraq and Afghanistan report high rates of posttraumatic stress disorder (PTSD), psychological distress, personal and family stress, functional impairment and needing but not obtaining health care. A new educational intervention, TEAM (Troop Education for Army Morale), is designed to reduce distress and foster adaptive functioning. TEAM is based on evidence informed principles of Psychological First Aid (PFA; safety, calming, connectedness, self-efficacy, hope/optimism) delivered through workshops, handouts, a website and phone line. Soldiers learn to use self-care skills, recognize when Soldiers need care, provide support (buddy care, spouse support), identify barriers to care and promote health care utilization when needed. MA Soldiers, randomized to TEAM or no intervention, complete questionnaires upon return from deployment and at 1, 2, 3, 6, and 9 months. Preliminary results with the first three cohorts show probable PTSD and probable depression are 31.9% and 26.1%, respectively, at one month post deployment. Work-related impairments, including working more slowly than usual, lost concentration, and fatigue, are high. On average, the TEAM program was rated as helpful in important post deployment coping areas such as recognizing problems and seeking help (social support, healthcare utilization), connecting and communicating with others, feeling safe, and using calming techniques to reduce arousal. These findings increase our knowledge of PFA based early interventions. Implications include the feasibility of early intervention with all military service members, first responders, disaster workers and others exposed to the dead.



TROOP EDUCATION FOR ARMY MORALE (TEAM) POST DEPLOYMENT EARLY EDUCATION PROGRAM FOR MORTUARY AFFAIRS SOLDIERS; RESULTS FROM THE FIRST YEAR

Quinn M. Biggs, Ph.D., M.P.H., Carol S. Fullerton, Ph.D., James E. McCarroll, Ph.D., MPH., LCDR Patcho Santiago, M.D., MPH., Christine Gray, M.P.H., David M. Benedek, M.D., John H. Newby, Ph.D., M.S.W., Stephanie N. Riley, B.S., Chad A. Spiegel, M.A., Natalie T. Kodsy, M.A., and Robert J. Ursano, M.D.



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BACKGROUND



U.S. Army Mortuary Affairs Soldiers (MA) recover, identify, and evacuate the remains of deceased military personnel and their personal effects from Iraq and Afghanistan. Exposure to death and the combat environment increases the risk for posttraumatic distress and adjustment difficulties.

NEW EDUCATIONAL INTERVENTION

TEAM (Troop Education for Army Morale): TEAM is a new education and skills training intervention to help MA soldiers and their spouses reduce distress and foster adaptive coping in the months after deployment. TEAM integrates resources in the social context of home and unit to enhance the natural role of spouse and buddy support. Spouses are offered an equivalent intervention.

Basis of the Intervention: TEAM training is based on the evidence-informed principles of Psychological First Aid (PFA)^{1,3} and Cognitive Behavioral Therapy (CBT)⁴.

Psychological First Aid:
PFA is designed to reduce the distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping through the principles of Safety, Calming, Connecting, Self-Efficacy, and Hope/Optimism.



Cognitive-Behavioral Therapy:
CBT is an approach to altering thoughts and beliefs that lead to distress and prevent PTSD successfully when administered early after trauma exposure. However, TEAM is education-based and NOT therapy or mental health treatment.

- Delivery of Intervention:**
- Interactive group workshops
 - Referral resources
 - Educational handouts
 - Concierge-type service
 - Toll-free phone line and email service
 - Stepped collaborative care model⁵
 - Website (resources, training materials)
 - Support through spouse and buddy

Goals: The training of Soldiers to:

- Develop self-care skills and increase adaptive coping in response to stress
- Identify when an individual is in need of care
- Provide early support to foster rapid recovery
- Build supportive relationships
- Improve communication skills
- Promote health care seeking when needed
- Overcome barriers to health care utilization
- Address health risk behaviors (e.g., alcohol use)



METHODS

Procedure: MA Soldiers at Fort Lee, Virginia were randomized to receive either the TEAM intervention (Workshop) or no intervention (Usual Services). Workshops were held at 1, 2, 3 & 6 months post deployment. Questionnaires were completed at return from deployment and 1, 2, 3, 6 & 9 months. Outcomes included psychiatric disorder (PTSD, depression), psychological distress, functional impairment, and impact of TEAM on post deployment readjustment.

Participants: 75 MA Soldiers (Workshop Group N=39; Usual Services N=36)

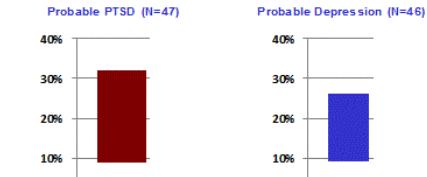
- Gender: 73.1% male; 26.9% female
- Age: range 19-50 years (M=28.58)
- Education: 1.5% HS; 43.3% HS/GED; 50.7% some college; 4.5% bachelors
- Rank: 16.4% Private or Private First Class; 65.7% Specialist or Corporal; 17.9% Sergeant (all enlisted)
- Race: 63.6% White; 16.7% Black; 12.1% Hispanic; 4.5% American Indian or Alaskan Native; 3.0% Asian or Pacific Islander
- Marital Status: 68.7% married; years M=4.76; 73.3% live with their spouse

Measures:

- **Probable PTSD:** PTSD Checklist (PCL-17): "How much you have been bothered by each problem in the past month" (1="not at all" to 5="extremely"). Probable PTSD if total symptom score ≥50 (range 17-85); 1 intrusion, 3 avoidance, 2 hyperarousal symptoms scored moderately or higher.
- **Probable Depression:** Patient Health Questionnaire (PHQ-9): Positive if 5 or more of 9 symptoms present "more than half the days" or "most days" in the past 2 weeks and at least 1 symptom is depressed mood or anhedonia.

PRELIMINARY RESULTS

PTSD and Depression (1 month post deployment)

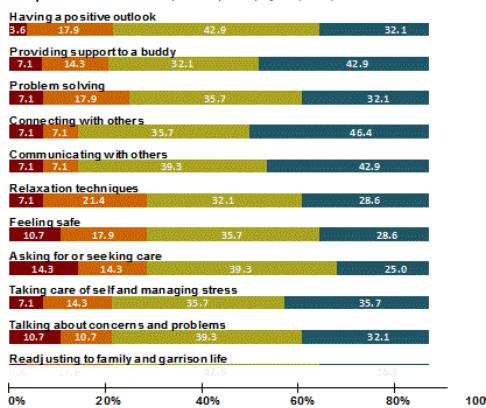


Work-Related Impairment (reported at least half of the time, 1 mo. post deploy.; N=47)

- 70.2% Felt fatigued
- 40.4% Worked more slowly than usual
- 53.2% Lost concentration

PRELIMINARY RESULTS (CONT.)

Helpfulness of TEAM (2-9 mos. post deployment; N=28)



Limitations

- Self-selection to study and attendance
- Self-report measures
- Preliminary data (2 cohorts completed, 1 in progress, 2 more cohorts expected)

SUMMARY AND IMPACT

- ♦ These preliminary data suggest Mortuary Affairs Soldiers returning from Iraq and Afghanistan have high rates of PTSD and depression.
- ♦ Soldiers returning from deployment report benefit from Psychological First Aid and Cognitive Behavioral Therapy-based early educational intervention.
- ♦ Most participants described TEAM as being "Moderately" or "Quite a bit" helpful.
- ♦ TEAM enhances the natural role of spouse and buddy support and addresses barriers to health care utilization.
- ♦ Interventions of this type are needed due to the high number of Soldiers returning from deployment with psychiatric disorders and low mental health care utilization⁶.
- ♦ Findings have implications for use of this intervention with Soldiers in other military branches, first responders, disaster workers and others exposed to the dead.

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Abstract

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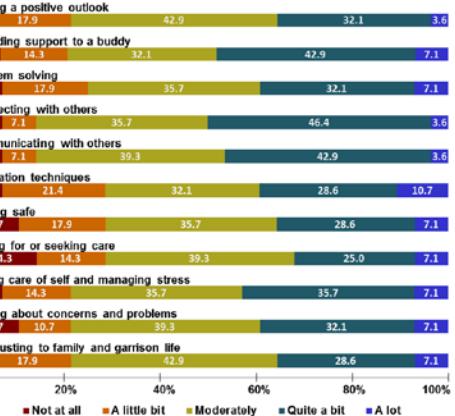
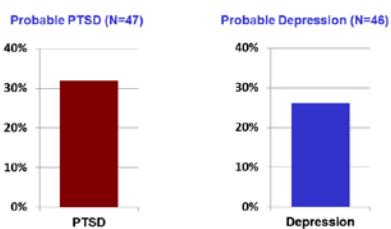


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BACKGROUND	METHODS	PRELIMINARY RESULTS (CONT.)																																																																								
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However, TEAM is education-based and NOT therapy or mental health treatment.</p> <p>Delivery of Intervention:</p> <ul style="list-style-type: none"> Interactive group workshops Educational handouts Toll-free phone line and email service Website (resources, training materials) Referral resources Concierge-type service Stepped collaborative care model⁵ Support through spouse and buddy <p>Goals: The training of Soldiers to:</p> <ul style="list-style-type: none"> Develop self-care skills and increase adaptive coping in response to stress Identify when an individual is in need of care Provide early support to foster rapid recovery Build supportive relationships Improve communication skills Promote health care seeking when needed Overcome barriers to health care utilization Address health risk behaviors (e.g., alcohol use) 	<p>PRELIMINARY RESULTS</p> <p>PTSD and Depression (1 month post deployment)</p>  <table border="1"> <thead> <tr> <th>Condition</th> <th>Probability</th> </tr> </thead> <tbody> <tr> <td>PTSD</td> <td>~30%</td> </tr> <tr> <td>Depression</td> <td>~25%</td> </tr> </tbody> </table> <p>Work-Related Impairment (reported at least half of the time, 1 mo. post deploy; N=47)</p> <ul style="list-style-type: none"> 70.2% Felt fatigued 53.2% Lost concentration 40.4% Worked more slowly than usual 	Condition	Probability	PTSD	~30%	Depression	~25%	<p>Limitations:</p> <ul style="list-style-type: none"> Self-selection to study and attendance Self-report measures <p>* Preliminary data (2 cohorts completed, 1 in progress, 2 more cohorts expected)</p> <p>SUMMARY AND IMPACT</p> <ul style="list-style-type: none"> These preliminary data suggest Mortuary Affairs Soldiers returning from Iraq and Afghanistan have high rates of PTSD and depression. 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August, 2011

Empirical evidence for a Psychological First Aid-based intervention in soldiers post-deployment.

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Abstract

Statement of the Problem

The development of interventions for returning soldiers and their families is critical to the mental and behavioral health of soldiers returning from deployments to Iraq and Afghanistan. Mortuary Affairs (MA) soldiers in the U.S. Army perform duties involving recovery, identification and evacuation of the dead are at increased risk for development of distress, disorder and health risk behaviors such as increased use of alcohol and tobacco. Studies suggest that regardless of profession, training, or past experience, duties involving recovery and identification of human remains are associated with acute and long-term psychological distress and psychiatric disorders. Mortuary Affairs soldiers report high rates of probable posttraumatic stress disorder (PTSD), psychological distress, personal and family stress, functional impairment. They report needing health care but not obtaining needed care, suggesting the importance of better understanding barriers to health care utilization. To our knowledge, there are no post-deployment interventions designed specifically for MA soldiers, spouses and buddies. We report preliminary findings of a randomized controlled intervention study using the principles of Psychological First Aid as an intervention in the first 9 months post-deployment in Mortuary Affairs Soldiers.

Subjects

Mortuary Soldiers are recruited into the study within a month of return from deployment to Iraq or Afghanistan. Participation is voluntary and IRB-approved Informed Consent is obtained from all participants. Participants are enlisted US Army personnel. Thus far, 86 soldiers have been recruited into the study across 4 cohorts. Study participants are 70.9% male, 29.1% female, age 19-50 years old ($M=28.58$). They are 63.6% White; 16.7% Black; 12.1% Hispanic; 4.5% Native

American; 3.0% Asian. The majority (68.7%) are married; the mean number of years married is 4.76.

Procedures

This longitudinal, controlled intervention study randomizes MA soldiers into intervention and control groups within a month of return from deployment. All study participants complete questionnaires at 1, 2, 3, 6, and 9 months that include questions about deployment experiences, mental health including PTSD (PCL-17) and depression (PHQ-9), health care utilization, barriers to care, social support, health risk behaviors, and evaluation of aspects of the intervention. The intervention, TEAM (Troop Education for Army Morale), is based on evidence-informed principles of Psychological First Aid (safety, calming, connectedness, self-efficacy, and hope/optimism), and is delivered through workshops conducted at 1, 2, 3, and 6 months post-deployment, as well as handouts, a website and phone line. Spouses of intervention-group soldiers are also provided the opportunity to attend separate workshops with similar educational content. Both soldiers and their spouses are taught to use self-care skills, recognize when soldiers need care, provide support (buddy care, spouse support), identify barriers to care and promote health care utilization when needed.

Results

Preliminary results from the first 4 cohorts will be presented. Data to date indicate rates of probable PTSD and probable depression to be 31.9% and 26.1%, respectively, in soldiers one month post-deployment. Among participants, 14.9% reported obtaining medical care for emotional or family problems, and 34.0% felt in need of medical care but did not obtain any. Of the participants, 28.9% reported that they drank more alcohol than usual or re-started after quitting, 22.2% consume 5 or more alcohol drinks at one time, and 40.5% increased tobacco use or re-started after quitting. Longitudinal data on 4 cohorts of Mortuary Affairs soldiers will be presented. There is a trend indicating the effectiveness of the TEAM intervention. Specifically, findings are presented on disorder, distress and health risk behaviors (e.g., increases in alcohol and tobacco use) for the intervention and control groups at 1, 2, 3 and 6 months post-deployment in order to evaluate the effectiveness of our TEAM intervention. Multivariate logistic analyses are used to examine the mediating effects of variables such as social support. Barriers to health care utilization will also be examined and reported.

Conclusions

Preliminary results suggest that MA soldiers are at increased risk for development of post-deployment disorders, distress and health risk behaviors. Preliminary results also suggest a trend that the TEAM program utilizing principles of Psychological First Aid may be an effective intervention for soldiers returning from deployment. This study potentially provides a model for reducing stress and increasing adaptive functioning that can be adapted to other soldiers and disaster workers.

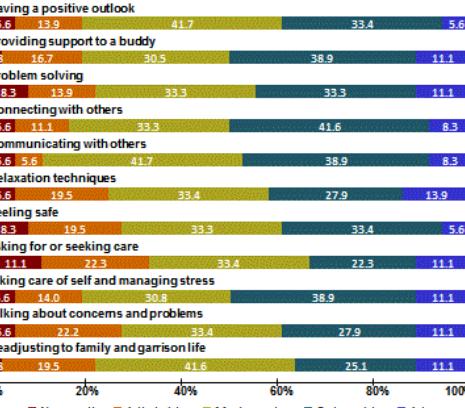
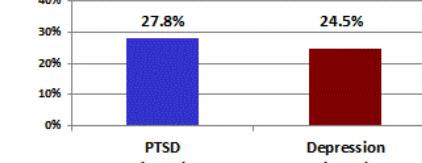


EMPIRICAL EVIDENCE FOR A PSYCHOLOGICAL FIRST AID-BASED INTERVENTION IN SOLDIERS POST-DEPLOYMENT

Christine L. Gray, M.P.H., Carol S. Fullerton, Ph.D., Quinn M. Biggs, Ph.D., M.P.H., James McCarroll, Ph.D., M.P.H., LCDR Patcho Santiago, M.D., M.P.H.,
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Center for the Study of Traumatic Stress, Department of Psychiatry, Uniformed Services University of the Health Sciences, Bethesda, MD

BACKGROUND	METHODS	PRELIMINARY RESULTS (CONT.)																																																																								
 <p>U.S. Army Mortuary Affairs Soldiers (MA) recover, identify, and evacuate the remains of deceased military personnel and their personal effects from Iraq and Afghanistan. Those duties increase their risk for the development of distress, disorder and health risk behaviors. Evaluation of interventions that aim to reduce barriers to health care utilization and promote adaptive coping is</p>	<p>Procedures: MA Soldiers at Fort Lee, Va. were randomized to receive the TEAM intervention (Workshop) or no intervention (Usual Services). Workshops were held at 1, 2, 3 & 6 months post deployment. Questionnaires were completed at return from deployment and 1, 2, 3, 6 & 9 months. Outcomes included psychiatric disorder (PTSD, depression), health risk behaviors, barriers to seeking mental health care, and impact of TEAM on post deployment readjustment.</p> <p>Participants: 86 MA Soldiers (Workshop Group N=46; Usual Services N=40)</p> <ul style="list-style-type: none"> Gender: 70.1% male; 29.9% female Age: range 19-50 years (M=28.26) Education: 0% HS; 37.7% HS/GED; 55.8% some college; 6.5% bachelors Rank: 10.4% Private or Private First Class; 81.1% Specialist or Corporal; 7.8% Sergeant (all enlisted) Race: 80.5% White; 15.8% Black; 13.2% Hispanic; 6.6% American Indian or Alaskan Native; 3.9% Asian or Pacific Islander Marital Status: 84.9% married; years M=4.27; 73.1% live with their spouse <p>Measures:</p> <ul style="list-style-type: none"> Probable PTSD: PTSD Checklist (PCL-17): Probable PTSD if total symptom score ≥ 50 (range 17-85). Probable Depression: Patient Health Questionnaire (PHQ-9): Positive if 5 or more of 9 symptoms present and at least 1 symptom is depressed mood or anhedonia. 	<p>Helpfulness of TEAM: (2-9 mos. post deployment; N=30)</p>  <table border="1"> <thead> <tr> <th>Dimension</th> <th>Not at all</th> <th>A little bit</th> <th>Moderately</th> <th>Quite a bit</th> <th>A lot</th> </tr> </thead> <tbody> <tr> <td>Having a positive outlook</td> <td>5.6</td> <td>13.9</td> <td>41.7</td> <td>33.4</td> <td>5.6</td> </tr> <tr> <td>Providing support to a buddy</td> <td>7.8</td> <td>16.7</td> <td>30.5</td> <td>38.9</td> <td>11.1</td> </tr> <tr> <td>Problem solving</td> <td>8.3</td> <td>13.9</td> <td>33.3</td> <td>33.3</td> <td>11.1</td> </tr> <tr> <td>Connecting with others</td> <td>5.6</td> <td>11.1</td> <td>33.3</td> <td>41.6</td> <td>6.3</td> </tr> <tr> <td>Communicating with others</td> <td>5.6</td> <td>5.6</td> <td>41.7</td> <td>35.9</td> <td>8.3</td> </tr> <tr> <td>Relaxation techniques</td> <td>5.6</td> <td>19.5</td> <td>33.4</td> <td>27.9</td> <td>13.9</td> </tr> <tr> <td>Feeling safe</td> <td>8.3</td> <td>19.5</td> <td>33.3</td> <td>33.4</td> <td>5.6</td> </tr> <tr> <td>Asking for or seeking care</td> <td>11.1</td> <td>22.3</td> <td>33.4</td> <td>22.3</td> <td>11.1</td> </tr> <tr> <td>Taking care of self and managing stress</td> <td>5.6</td> <td>14.0</td> <td>30.8</td> <td>38.9</td> <td>11.1</td> </tr> <tr> <td>Talking about concerns and problems</td> <td>5.6</td> <td>22.2</td> <td>33.4</td> <td>27.9</td> <td>11.1</td> </tr> <tr> <td>Readjusting to family and garrison life</td> <td>7.8</td> <td>19.5</td> <td>41.6</td> <td>25.1</td> <td>11.1</td> </tr> </tbody> </table>	Dimension	Not at all	A little bit	Moderately	Quite a bit	A lot	Having a positive outlook	5.6	13.9	41.7	33.4	5.6	Providing support to a buddy	7.8	16.7	30.5	38.9	11.1	Problem solving	8.3	13.9	33.3	33.3	11.1	Connecting with others	5.6	11.1	33.3	41.6	6.3	Communicating with others	5.6	5.6	41.7	35.9	8.3	Relaxation techniques	5.6	19.5	33.4	27.9	13.9	Feeling safe	8.3	19.5	33.3	33.4	5.6	Asking for or seeking care	11.1	22.3	33.4	22.3	11.1	Taking care of self and managing stress	5.6	14.0	30.8	38.9	11.1	Talking about concerns and problems	5.6	22.2	33.4	27.9	11.1	Readjusting to family and garrison life	7.8	19.5	41.6	25.1	11.1
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<p>TEAM (Troop Education for Army Morale): TEAM is a new education and skills training intervention to help MASoldiers and their spouses reduce distress and foster adaptive coping in the months after deployment. TEAM integrates resources in the social context of home and unit to enhance the natural role of spouse and buddy support. Spouses are offered an equivalent intervention.</p> <p>Basis of the Intervention: TEAM training is based on the evidence-informed principles of Psychological First Aid (PFA)^{1,2} and Cognitive Behavioral Therapy (CBT)⁴.</p> <p>Psychological First Aid: PFA is designed to reduce the distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping through the principles of Safety, Calming, Connecting, Self-Efficacy, and Hope/Optimism.</p> <p>Cognitive-Behavioral Therapy: CBT is an approach to altering thoughts and beliefs that lead to emotions. It has been shown to treat and prevent PTSD successfully when administered early after trauma exposure. However, TEAM is education-based and NOT therapy or mental health treatment.</p> <p>Delivery of Intervention:</p> <ul style="list-style-type: none"> Interactive group workshops Educational handouts Toll-free phone line and email service Website (resources, training materials) Referral resources Conierge-type service Stepped collaborative care model⁵ Support through spouse and buddy <p>Goals: The training of Soldiers to:</p> <ul style="list-style-type: none"> Develop self-care skills and increase adaptive coping in response to stress Identify when an individual is in need of care Provide early support to foster rapid recovery Build supportive relationships Improve communication skills Promote health care seeking when needed Overcome barriers to health care utilization Address health risk behaviors (e.g., alcohol use) 	<p>PRELIMINARY RESULTS</p> <p>Probable PTSD and Probable Depression (1 month post-deployment)</p>  <table border="1"> <thead> <tr> <th>Condition</th> <th>N</th> <th>Percentage</th> </tr> </thead> <tbody> <tr> <td>PTSD (N=54)</td> <td>54</td> <td>27.8%</td> </tr> <tr> <td>Depression (N=53)</td> <td>53</td> <td>24.5%</td> </tr> </tbody> </table> <p>Health Behaviors (1 month post-deployment)</p> <ul style="list-style-type: none"> 23.1% Drank more than usual in the past month 19.2% Usually have 5 or more drinks at one time 31.5% Increased tobacco use in the past month 33.3% Felt in need of medical care, but did not obtain it <p>Barriers to Care (1 month post-deployment)</p> <ul style="list-style-type: none"> 24.1% Believe unit members would lose confidence in them 18.6% Would be too embarrassed 18.5% Don't trust mental health professionals 31.5% Worry they would be seen as weak 	Condition	N	Percentage	PTSD (N=54)	54	27.8%	Depression (N=53)	53	24.5%	<p>Limitations</p> <ul style="list-style-type: none"> Self-selection to study and attendance Self-report measures Preliminary data (3 cohorts completed, 2 in progress, 1 more cohort expected) <p>SUMMARY AND IMPACT</p> <ul style="list-style-type: none"> These preliminary data suggest Mortuary Affairs Soldiers returning from Iraq and Afghanistan have high rates of PTSD and depression. Soldiers returning from deployment report benefit from Psychological First Aid and Cognitive Behavioral Therapy-based early educational intervention. Most participants described TEAM as being "Moderately" or "Quite a bit" helpful. TEAM enhances the natural role of spouse and buddy support and addresses barriers to health care utilization. Interventions of this type are needed due to the high number of Soldiers returning from deployment with psychiatric disorders and low mental health care utilization⁶. Findings have implications for use of this intervention with Soldiers in other military branches, first responders, disaster workers and others exposed to the dead. <p>References:</p> <ol style="list-style-type: none"> 1. Gieseler DM & Ruland CS (2007). Translating the essential elements into programs and practice. <i>Psychiatry</i>, 70, 346-354. 2. Plogstis SE et al. (2007). Five essential elements of immediate and mid-term mass trauma intervention. <i>Annals of Emergency Medicine</i>, 49, 323-325. 3. McFayden K et al. (2007). Psychological debriefing for acute stress reactions. <i>CDS Spectrum</i>, 10, 184-187. 4. Slaten RA (2003). Psychiatric approaches to acute stress reactions. <i>CDS Spectrum</i>, 6, 49-52. 5. Ursano RJ et al. (2004). A stepped collaborative care model for veterans with severe mental illness. <i>Archives of General Psychiatry</i>, 61, 495-505. 6. Ursano RJ et al. (2004). The need for a national mental health strategy for veterans. <i>Journal of the American Medical Association</i>, 291, 1322-1323. <p>Funded by U.S. Army Medical Research & Materiel Command, Congressionally Directed Medical Research Program Award W81XWH-05-2-0150</p>																																																															
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December, 2011

Evidence for TEAM: A post deployment Psychological First Aid-based education program for U.S. Army mortuary affairs soldiers

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Abstract

U.S. Army Mortuary Affairs Soldiers (MA) who serve in Iraq and Afghanistan are at high risk for post-deployment psychological distress and psychiatric disorder. A new educational intervention, TEAM (Troop Education for Army Morale), is designed to reduce distress and foster adaptive functioning. TEAM is based on evidence informed principles of Psychological First Aid and delivered through workshops, handouts, a website, and phone line. Soldiers learn to use self-care skills, provide support (buddy care), and identify barriers to care. MA Soldiers, randomized to TEAM or no intervention, complete questionnaires upon return from deployment and at 1, 2, 3, 6, and 9 months. TEAM workshops are held at 1, 2, 3, and 6 months. At one month post-deployment, probable PTSD and probable depression were 27.8% and 24.5%, respectively; health risk behaviors were high (23.1% drank more alcohol than usual, 31.5% increased tobacco use); and barriers to seeking mental health care were considerable. On average, TEAM was rated as helpful in important coping areas (recognizing problems, connecting and communicating with others, seeking help, feeling safe, using calming techniques to reduce arousal). Implications include the feasibility of early intervention with all military service members, first responders, disaster workers and others exposed to the dead.

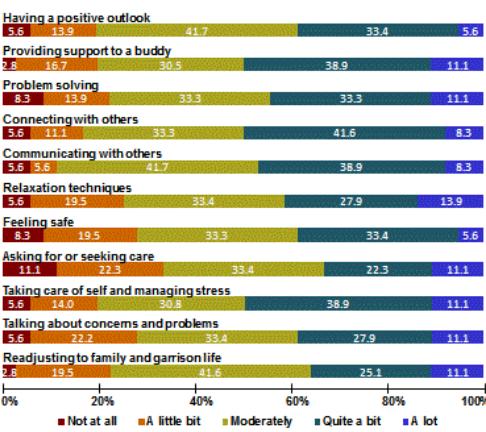
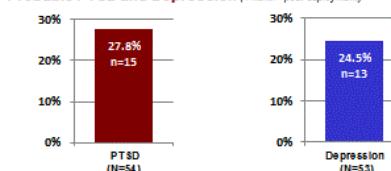


EVIDENCE FOR TEAM: A POST DEPLOYMENT PSYCHOLOGICAL FIRST AID-BASED EDUCATION PROGRAM FOR U.S. ARMY MORTUARY AFFAIRS SOLDIERS

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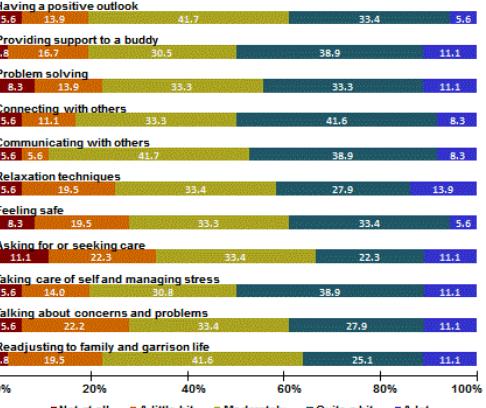
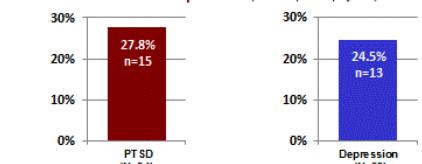


TROOP EDUCATION FOR ARMY MORALE (TEAM): A POST DEPLOYMENT EDUCATIONAL PROGRAM FOR MORTUARY AFFAIRS SOLDIERS; RESULTS FROM THE FIRST TWO YEARS



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Abstract

U.S. Army Mortuary Affairs Soldiers (MA) who serve in Iraq and Afghanistan are at high risk for post-deployment psychological distress and psychiatric disorder. A new educational intervention, TEAM (Troop Education for Army Morale), is designed to reduce distress and foster adaptive functioning. TEAM is based on evidence informed principles of Psychological First Aid and delivered through workshops, handouts, a website, and phone line. Soldiers learn to use self-care skills, provide support (buddy care), and identify barriers to care. MA Soldiers, randomized to TEAM or no intervention, complete questionnaires upon return from deployment and at 1, 2, 3, 6, and 9 months. TEAM workshops are held at 1, 2, 3, and 6 months. At one month post-deployment, probable PTSD and probable depression were 27.8% and 24.5%, respectively; health risk behaviors were high (31.5% increased tobacco use, 23.1% drank more alcohol than usual); and barriers to seeking mental health care were considerable. On average, TEAM was rated as helpful in important coping areas (recognizing problems, connecting and communicating with others, seeking help, feeling safe, using calming techniques to reduce arousal). Implications include the feasibility of early intervention with all military service members, first responders, disaster workers and others exposed to the dead.

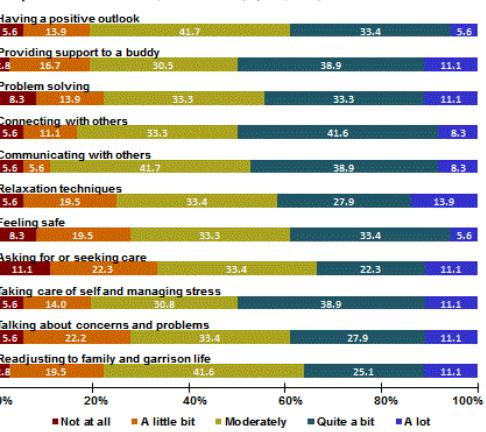
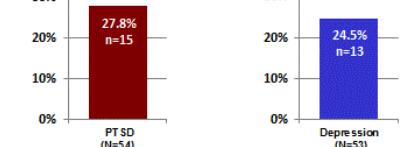


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	<p>U.S. Army Mortuary Affairs Soldiers (MA) recover, identify, and evacuate the remains of deceased military personnel and their personal effects from Iraq and Afghanistan. Exposure to death and the combat environment increases the risk for posttraumatic distress and adjustment difficulties.</p>	<p>Procedures: MA Soldiers at Fort Lee, Virginia were randomized to receive the TEAM intervention (Workshop) or no intervention (Usual Services). Workshops were held at 1, 2, 3 & 6 months post deployment. Questionnaires were completed at return from deployment and 1, 2, 3, 6 & 9 months. Outcomes included psychiatric disorder (PTSD, depression), health risk behaviors, barriers to seeking mental health care, and impact of TEAM on post deployment readjustment.</p> <p>Participants: 86 MA Soldiers (Workshop Group N=46; Usual Services N=40)</p> <ul style="list-style-type: none"> Gender: 70.1% male; 29.9% female Age: range 19-50 years (M=28.26) Education: 0%-HS, 37.7% HS/GED; 55.8% some college; 6.5% bachelors Rank: 10.4% Private or Private First Class; 81.1% Specialist or Corporal; 7.8% Sergeant (all enlisted) Race: 60.5% White; 15.8% Black; 13.2% Hispanic; 6.6% American Indian or Alaskan Native; 3.9% Asian or Pacific Islander Marital Status: 64.9% married; years M=4.27; 73.1% live with their spouse <p>Measures:</p> <ul style="list-style-type: none"> Probable PTSD: PTSD Checklist (PCL-17): Probable PTSD if total symptom score ≥ 50 (range 17-85). Probable Depression: Patient Health Questionnaire (PHQ-9): Positive if 5 or more of 9 symptoms present and at least 1 symptom is depressed mood or anhedonia. 	<p>Helpfulness of TEAM: (2-9 mos. Post-deployment; N=28)</p>  <table border="1"> <thead> <tr> <th>Component</th> <th>Not at all</th> <th>A little bit</th> <th>Moderately</th> <th>Quite a bit</th> <th>A lot</th> </tr> </thead> <tbody> <tr> <td>Having a positive outlook</td> <td>5.6</td> <td>13.9</td> <td>41.7</td> <td>33.4</td> <td>5.6</td> </tr> <tr> <td>Providing support to a buddy</td> <td>2.8</td> <td>16.7</td> <td>30.5</td> <td>38.9</td> <td>11.1</td> </tr> <tr> <td>Problem solving</td> <td>8.3</td> <td>13.9</td> <td>33.3</td> <td>33.3</td> <td>11.1</td> </tr> <tr> <td>Connecting with others</td> <td>5.6</td> <td>11.1</td> <td>33.3</td> <td>41.6</td> <td>8.3</td> </tr> <tr> <td>Communicating with others</td> <td>5.6</td> <td>5.6</td> <td>41.7</td> <td>38.9</td> <td>8.3</td> </tr> <tr> <td>Relaxation techniques</td> <td>5.6</td> <td>19.5</td> <td>33.4</td> <td>27.9</td> <td>15.9</td> </tr> <tr> <td>Feeling safe</td> <td>8.3</td> <td>19.5</td> <td>33.3</td> <td>33.4</td> <td>5.6</td> </tr> <tr> <td>Asking for or seeking care</td> <td>11.1</td> <td>22.3</td> <td>33.4</td> <td>22.3</td> <td>11.1</td> </tr> <tr> <td>Taking care of self and managing stress</td> <td>5.6</td> <td>14.0</td> <td>30.8</td> <td>38.9</td> <td>11.1</td> </tr> <tr> <td>Talking about concerns and problems</td> <td>5.6</td> <td>22.2</td> <td>33.4</td> <td>27.9</td> <td>11.1</td> </tr> <tr> <td>Readjusting to family and garrison life</td> <td>2.8</td> <td>19.5</td> <td>41.6</td> <td>25.1</td> <td>11.1</td> </tr> </tbody> </table>	Component	Not at all	A little bit	Moderately	Quite a bit	A lot	Having a positive outlook	5.6	13.9	41.7	33.4	5.6	Providing support to a buddy	2.8	16.7	30.5	38.9	11.1	Problem solving	8.3	13.9	33.3	33.3	11.1	Connecting with others	5.6	11.1	33.3	41.6	8.3	Communicating with others	5.6	5.6	41.7	38.9	8.3	Relaxation techniques	5.6	19.5	33.4	27.9	15.9	Feeling safe	8.3	19.5	33.3	33.4	5.6	Asking for or seeking care	11.1	22.3	33.4	22.3	11.1	Taking care of self and managing stress	5.6	14.0	30.8	38.9	11.1	Talking about concerns and problems	5.6	22.2	33.4	27.9	11.1	Readjusting to family and garrison life	2.8	19.5	41.6	25.1	11.1	
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September, 2012

(no accompanying abstract)



UNIFORMED SERVICES UNIVERSITY
of the Health Sciences

Mortuary Affairs Soldiers: Early Intervention and Altering Barriers to Care for Traumatic Stress and PTSD

Principal Investigator:
Carol S. Fullerton, Ph.D.

Presented by:
Quinn M. Biggs, Ph.D., M.P.H.



Center for the Study of Traumatic Stress

November, 2012

**The Impact of TEAM: An Innovative Post Deployment Intervention for Traumatic Stress
in U.S. Army Mortuary Affairs Soldiers**

Quinn M. Biggs, Ph.D., M.P.H.

Carol S. Fullerton, Ph.D.

Daniel Cox, Ph.D.

James E. McCarroll, Ph.D., M.P.H.

Robert J. Ursano, M.D.

Center for the Study of Traumatic Stress, Department of Psychiatry, Uniformed Services
University of the Health Sciences, 4301 Jones Bridge Road, Bethesda, MD 20814

Abstract

U.S. Army mortuary affairs soldiers (MA) returning from Iraq and Afghanistan report high rates of posttraumatic stress disorder (PTSD), personal and family stress, functional impairment and needing but not obtaining health care. TEAM (Troop Education for Army Morale), an innovative educational intervention, is designed to foster adaptive functioning and reduce distress, stigma, and barriers to care. Based on evidence informed principles of Psychological First Aid (safety, calming, self-efficacy, hope/optimism, connectedness), TEAM is delivered through workshops, handouts, a website and phone line. Soldiers and spouses learn skills for self-care, supporting others (buddy care, spouse support), and promoting health care utilization. MA soldiers, randomized to TEAM or a no intervention control group, completed questionnaires approximately 10 days, 1, 2, 3, 6 and 9 months post deployment. We present data on the impact of the TEAM intervention (vs. no intervention) on symptoms of PTSD and depression, morale, personal functioning, quality of life, social interactions, safety, and the helpfulness of specific components of TEAM (e.g., managing stress, relaxation, obtaining support). These data increase our knowledge of PFA-based early interventions. Implications include tailoring TEAM's components to high risk groups including other military populations, first responders, disaster workers, and others exposed to the dead.



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The Impact of TEAM: An Innovative Post Deployment Intervention for Traumatic Stress in U.S. Army Mortuary Affairs Soldiers

**Funding Source: Congressionally Directed Medical
Research Program (CDMRP)**

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Center for the Study of Traumatic Stress



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Center for the Study of Traumatic Stress

November, 2012

Adapting and Applying Empirically-Based Principles for Acute Stress Responses to the Chronic Stress Responses of Mortuary Affairs Soldiers

Daniel W. Cox, Ph.D.

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Abstract

Statement of the Problem

Mortuary Affairs (MA) soldiers in the U.S. Army perform duties involving evacuation of the dead from the theater of war. Regardless of profession, training, or past experience, recovery and identification of human remains have been associated with acute and long-term psychological distress. The development of post-deployment interventions for MA soldiers and their families is critical to their mental and behavioral health. To our knowledge, there are no post-deployment interventions designed specifically for this population.

Purpose

TEAM (Troop Education for Army Morale), is designed to reduce distress and foster adaptive functioning. TEAM is based on the evidence informed principles of Psychological First Aid (PFA) (safety, calming, connectedness, self-efficacy, hope/optimism) and Cognitive-Behavioral Therapy (CBT). It is delivered through workshops, handouts, a website, and a toll-free phone line. Soldiers and their spouses learn skills for care of self and others including how to (a) recognize soldiers in need, (b) provide support, (c) identify barriers to care, and (d) promote health care utilization.

Aims

Describe how we adapted an intervention for acute stress (PFA) for a population recovering from chronic stress (post-deployment MA soldiers).

Present the components of TEAM that soldiers found most and least helpful.

Participants

MA soldiers were recruited into the study approximately one month following their Middle East deployment. Ninety-four soldiers were recruited into the study across 6 cohorts. Study participants were 67.8% male, 32.2% female, and 19-50 years old ($M = 26.79$). They were 63.8% White; 15.5% Black; 10.3% Hispanic; 5.2% Native American; and 5.2% Asian. The majority were married (58.6%) and the mean number of years married was 3.86.

Analyses

Descriptive data will be presented (quantitative and qualitative) and non-parametric statistics will be employed to evaluate which components of TEAM MA soldiers perceived as most and least helpful.

Implications

Findings will increase our knowledge of soldiers' perceptions of TEAM. We can then adjust TEAM based on these perceptions to potentially increase potency and effectiveness.



ADAPTING AND APPLYING EMPIRICALLY-BASED PRINCIPLES FOR ACUTE STRESS RESPONSES TO THE CHRONIC STRESS RESPONSES OF MORTUARY AFFAIRS SOLDIERS

Daniel W. Cox, Ph.D., Carol S. Fullerton, Ph.D., Quinn M. Biggs, Ph.D., M.P.H., James E. McCarroll, Ph.D., M.P.H., Jessica Kansky, B.A., Alison Stupny, B.A., and Robert J. Ursano, M.D.



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May, 2013

Troop Education for Army Morale (TEAM): A Post Deployment Educational Intervention for Mortuary Affairs Soldiers: Preliminary Results from the First Three Years

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Abstract

U.S. Army mortuary affairs soldiers (MA) perform duties involving identification, processing, and evacuation of the dead from the theater of war. Such exposures to death and the dead have been associated with acute and long-term psychological distress and psychiatric disorder. TEAM (Troop Education for Army Morale) is an innovative educational intervention designed to reduce distress and foster adaptive functioning after return from deployment. TEAM is based on evidence informed principles of Psychological First Aid: safety, calming, connectedness, self-efficacy, and hope/optimism, and the intervention is delivered through workshops, handouts, a website, and phone line. Soldiers learn skills for self-care as well as support of others. A total of 89, MA soldiers, randomized to TEAM or a no intervention control group, completed questionnaires approximately 1, 2, 3, 4, 7 and 10 months post deployment. We present data on demographics, probable post traumatic stress disorder and depression, and preliminary multivariate models of the impact of the TEAM intervention (vs. no intervention). These data increase our knowledge of PFA-based early interventions. Implications include tailoring TEAM's components to high risk groups including other military populations, first responders, disaster workers, and others exposed to the dead.

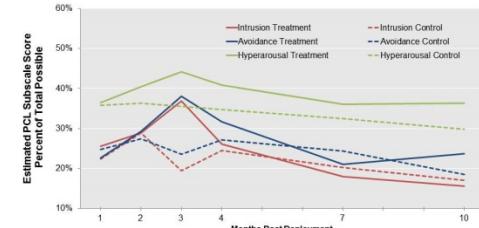
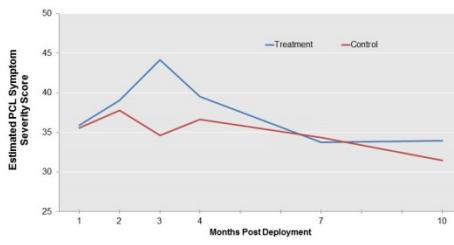
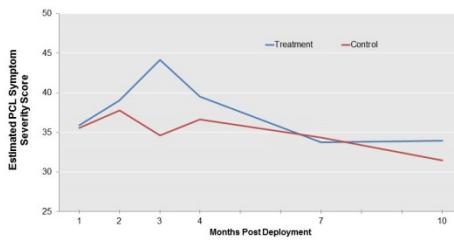


TROOP EDUCATION FOR ARMY MORALE (TEAM): A POST DEPLOYMENT EDUCATIONAL INTERVENTION FOR MORTUARY AFFAIRS SOLDIERS: PRELIMINARY RESULTS FROM THE FIRST THREE YEARS

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BACKGROUND	METHODS	PRELIMINARY RESULTS (CONT.)
 <p>U.S. Army Mortuary Affairs Soldiers (MA) recover, identify, and evacuate the remains of deceased military personnel and their personal effects from Iraq and Afghanistan. Exposure to death and the combat environment increases the risk for posttraumatic distress and adjustment difficulties.</p>	<p>Procedures: MA Soldiers at Fort Lee, Virginia were randomized to receive the TEAM intervention (Workshop) or no intervention (Usual Services). Workshops were held at 2, 3, 4 & 7 months post deployment. Questionnaires were completed at return from deployment and 2, 3, 4, 7 & 10 months. Outcomes included PTSD symptom severity.</p> <p>Participants: 89 MA Soldiers (Workshop Group N=48; Usual Services N=41)</p> <ul style="list-style-type: none"> Gender: 69.7% male; 30.3% female Age: range 19-50 years (M=28.2) Education: 50.6% High School/GED; 49.4% some college, tech school, bachelors Rank: 20.2% Private or Private First Class; 64.0% Specialist or Corporal; 15.7% Sergeant (all enlisted) Race: 58.4% White; 18.0% Hispanic; 23.6% Non-White/Non-Hispanic Marital Status: 64.0% married; 49.4% live with spouse <p>Measures:</p> <ul style="list-style-type: none"> PTSD Symptoms: PTSD Checklist (PCL-17) severity score (total score; range 17-85) and standardized intrusion, avoidance, and hyperarousal subscale scores. <p>Analyses:</p> <ul style="list-style-type: none"> Linear Mixed Modeling: The longitudinal effect of treatment on PCL-17 scores was derived from a linear mixed model using the PCL score as the dependent variable and time (six time points: baseline and five follow-ups), treatment (two groups: treatment and control), and the interaction between time and treatment as independent variables. Baseline assessment scores for gender (male vs. female) and having children (yes vs. no) were used as controls to adjust for potential confounding effects in estimating the mixed model. The two control variables were rescaled to be centered about their means 	<ul style="list-style-type: none"> There is no overall effect of treatment, time, or treatment*time on PCL total score. At month 3, PCL scores of the Treatment Group were significantly higher (9.5, SE = 4.1) than the Control Group (179) = 2.33, $p = .02$. <p>Linear Mixed Model of Longitudinal Trajectories of Standardized PCL-17 Intrusion, Avoidance, and Hyperarousal Subscale Scores (N = 69)</p>  <p>PRELIMINARY RESULTS</p> <p>Linear Mixed Model of Longitudinal Trajectories of PCL-17 Total Score (N = 69)</p>  <ul style="list-style-type: none"> Intrusion – Time by treatment interaction ($p < .01$). Groups were significantly different at month 3 ($p = .01$). Avoidance – Groups were significantly different month 3 ($p = .03$). Hyperarousal – When the subscale scores are standardized, hyperarousal symptoms are the highest. However, there were no group differences. <p>Limitations: self-selection to study and attendance, self-report, and preliminary data.</p>
<p>TEAM (Troop Education for Army Morale): TEAM is a new education and skills training intervention to help MA Soldiers and their spouses reduce distress and foster adaptive coping in the months after deployment. TEAM integrates resources in the social context of home and unit to enhance the natural role of spouse and buddy support. Spouses are offered an equivalent intervention.</p> <p>Basis of the Intervention: TEAM training is based on the evidence-informed principles of Psychological First Aid (PFA)^{1,3} and Cognitive Behavioral Therapy (CBT)⁴.</p> <p>Psychological First Aid:</p> <p>PFA is designed to reduce the distress caused by traumatic events and to foster short- and long-term adaptive functioning and coping through the principles of Safety, Calming, Connecting, Self-Efficacy, and Hope/Optimism.</p> <p>Cognitive-Behavioral Therapy:</p> <p>CBT is an approach to altering thoughts and beliefs that lead to emotions. It has been shown to treat PTSD successfully when administered early after trauma exposure. However, TEAM is education-based and NOT therapy or mental health treatment.</p> <p>Delivery of Intervention:</p> <ul style="list-style-type: none"> Interactive group workshops Educational handouts Toll-free phone line and email service Website (resources, training materials) Referral resources Concierge-type service Stepped collaborative care model⁵ Support through spouse and buddy <p>Goals: The training of Soldiers to:</p> <ul style="list-style-type: none"> Develop self-care skills and increase adaptive coping in response to stress Identify when an individual is in need of care Provide early support to foster rapid recovery Build supportive relationships Improve communication skills Promote health care seeking when needed Overcome barriers to health care utilization Address health risk behaviors (e.g., alcohol use) 	<p>PRELIMINARY RESULTS</p> <p>Linear Mixed Model of Longitudinal Trajectories of PCL-17 Total Score (N = 69)</p>  <ul style="list-style-type: none"> Treatment Group scores trend higher than Control Group scores during the first months of the intervention. The direction of this trend is contrary to expectation. 	<p>These preliminary data indicate that Mortuary Affairs Soldiers returning from deployment to the Middle East have high rates of PTSD symptoms.</p> <p>There was no overall effect of treatment, time, or a treatment-by-time interaction on the PCL-17 score.</p> <p>Treatment group scores trend higher in early months then return to level of Controls.</p> <p>Longer-term studies are needed to determine if there are benefits beyond 10 months.</p> <p>Further analyses will determine TEAM's effect on other measures of health and well-being.</p> <p>Findings have implications for adaptation of this intervention for other military branches, first responders, disaster workers and others exposed to the dead.</p> <p><small>References:</small></p> <p>¹Biggs QM & Fullerton CS (2007). Translating the essential elements into programs and practice. <i>Psychiatry</i>, 70, 345-348.</p> <p>²Hobelie SE et al (2007). Five essential elements of immediate and mid-term mass trauma intervention: Empirical evidence. <i>Psychiatry</i>, 70, 283-315.</p> <p>³National Child Traumatic Stress Network, Psychological First Aid Field Operations Guide, 2nd Ed. 2006. Available: www.nctrc.org.</p> <p>⁴Resnick H et al (2002). Cognitive behavioral therapy for PTSD: A meta-analysis. <i>Psychological Bulletin</i>, 129, 21-39.</p> <p>⁵Zlotkin D et al (2004). A randomized effectiveness trial of stepped collaborative care for acutely injured trauma survivors. <i>Archives of General Psychiatry</i>, 61, 496-506.</p> <p>Funded by U.S. Army Medical Research & Materiel Command, Congressionally Directed Medical Research Program Award W81XWH-06-2-0180</p>

November, 2014

Effectiveness of Post-Deployment Early Intervention for U.S. Army Mortuary Affairs Soldiers: Results from Four Years

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Abstract

U.S. Army mortuary affairs soldiers (MA) report high rates of posttraumatic stress disorder (PTSD), depression, personal and family stress, and functional impairment post deployment. We present data from four years (10 cohorts) of the TEAM (Troop Education for Army Morale) study, an innovative educational intervention designed to foster adaptive functioning and reduce distress, stigma, and barriers to care. Based on evidence informed principles of Psychological First Aid (safety, calming, self-efficacy, hope/optimism, connectedness), TEAM is delivered through workshops, handouts, a website and phone line. Soldiers and spouses learn skills for self-care, supporting others (buddy care, spouse support), and promoting health care utilization. MA soldiers, randomized to TEAM or a no intervention control group, completed questionnaires approximately 1, 2, 3, 4, 7 and 10 months post deployment. Results include the impact of the intervention on symptoms of PTSD and depression, quality of life, personal functioning, social interactions, morale, and the helpfulness of specific components of TEAM (e.g., managing stress, reducing arousal). These data increase our knowledge of PFA-based early interventions. Implications include tailoring TEAM's components to high risk groups including other military populations, first responders, disaster workers, and others exposed to the dead.



UNIFORMED SERVICES UNIVERSITY
of the Health Sciences

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Center for the Study of Traumatic Stress

Inventions, Patents and Licenses

Nothing to report

Reportable Outcomes

Conference Presentations

Biggs, Q. M., Fullerton, C. S., Benedek, D. M., McCarroll, J. E., Newby, J. H., & Ursano, R. J.

(April, 2009). Early care for psychological trauma: Innovations in teaching and delivery.

Poster presented at the 4th Annual Conference on Neurobiology of Amygdala and Stress:
Molecules in a Fearful Mind, USUHS, Bethesda, Maryland.

Biggs, Q. M., Fullerton, C. S., Benedek, D. M., McCarroll, J. E., Newby, J. H., & Ursano, R. J.

(June, 2009). Early care for psychological trauma: Innovations in teaching and delivery.

Poster presented at Education Day 2009, USUHS, Bethesda, Maryland.

Biggs, Q. M., Fullerton, C. S., Cox, D. W., McCarroll, J. E., Kansky, J., Stuppy, A., & Ursano, R. J.

(May, 2012). Troop Educational for Army Morale (TEAM): A post deployment educational program for Mortuary Affairs Soldiers; results from the first two years. Poster presented at Research Days, USUHS, Bethesda, Maryland.

Biggs, Q. M., Fullerton, C. S., Cox, D. W., McCarroll, J. E., Kansky, J., Stuppy, A., & Ursano, R. J.

(November, 2012). The impact of TEAM: An innovative post deployment intervention for traumatic stress in U.S. Army Mortuary Affairs Soldiers. Oral presentation given at the International Society for Traumatic Stress Studies Annual Meeting, Los Angeles, California.

Biggs, Q. M., Fullerton, C. S., Gray, C., McCarroll, J. E., Benedek, D. M., Santiago, P., & Ursano, R. J. (December, 2011). Evidence for TEAM: A post deployment Psychological First Aid-based education program for U.S. Army Mortuary Affairs Soldiers. Poster presented at the

4th Annual Trauma Spectrum Conference, National Institutes of Health, Bethesda, Maryland.

Biggs, Q. M., Fullerton, C. S., McCarroll, J. E., Benedek, D. M., Newby, J. H., & Ursano, R. J. (May, 2009). Early intervention for posttraumatic stress disorder in Mortuary Affairs Soldiers. Poster presented at Research Week, USUHS, Bethesda, Maryland.

Biggs, Q. M., Fullerton, C. S., McCarroll, J. E., Benedek, D. M., Newby, J. H., & Ursano, R. J. (November, 2009). Early intervention for posttraumatic stress disorder in Mortuary Affairs Soldiers. Poster presented at the International Society for Traumatic Stress Studies Annual Meeting, Atlanta, Georgia.

Biggs, Q. M., Fullerton, C. S., McCarroll, J. E., Gray, C., Santiago, P., Newby, J. H., Benedek, D. M., Kodusy, N. T., Riley, S. N., Spiegel, C. A., & Ursano, R. J. (November, 2010). TEAM: an early educational intervention for Mortuary Affairs Soldiers post deployment; preliminary results from the first three cohorts. Poster presented at the International Society for Traumatic Stress Studies Annual Meeting, Montreal, Canada.

Biggs, Q. M., Fullerton, C. S., McCarroll, J. E., Kansky, J., Hrank, K., Dacuyan, N., Zatzick, D., & Ursano, R. J. (November, 2014). Effectiveness of Post-Deployment Early Intervention for U.S. Army Mortuary Affairs Soldiers: Results from Four Years. Oral presentation given at the International Society for Traumatic Stress Studies Annual Meeting, Miami, Florida.

Biggs, Q. M., Fullerton, C. S., McCarroll, J. E., Santiago, P., Gray, C., Benedek, D. M., Newby, J. H., Riley, S. N., Spiegel, C. A., Kodusy, N. T., & Ursano, R. J. (April, 2011). Troop Educational for Army Morale (TEAM) post deployment early educational program for Mortuary Affairs Soldiers; results from the first year. Poster presented at the 6th Annual Conference on Amygdala, Stress and PTSD: Fear in the Human Mind, USUHS, Bethesda,

Maryland.

Biggs, Q. M., Fullerton, C. S., McCarroll, J. E., Santiago, P., Gray, C., Benedek, D. M., Newby, J. H., Riley, S. N., Spiegel, C. A., Kodsy, N. T., & Ursano, R. J. (May, 2011). Troop Educational for Army Morale (TEAM) post deployment early educational program for Mortuary Affairs Soldiers; results from the first year. Poster presented at Research Week, USUHS, Bethesda, Maryland.

Biggs, Q. M., Fullerton, C. S., McCarroll, J. E., Santiago, P., Gray, C., & Ursano, R. J. (April, 2010). Early educational intervention for Mortuary Affairs Soldiers post deployment: Preliminary results. Poster presented at the 5th Annual Conference on Neurobiology of Amygdala, Stress and PTSD: How stress shapes the mind, USUHS, Bethesda, Maryland.

Biggs, Q. M., Fullerton, C. S., McCarroll, J. E., Santiago, P., Gray, C., & Ursano, R. J. (May, 2010). Early educational intervention for Mortuary Affairs Soldiers post deployment: Preliminary results. Poster Presented at Research Week, USUHS, Bethesda, Maryland.

Biggs, Q. M., Fullerton, C. S., McCarroll, J. E., Stuppy, A., Kansky, J., & Ursano, R. J. (May, 2013). Troop Educational for Army Morale (TEAM): A post deployment educational intervention for Mortuary Affairs Soldiers; preliminary results from the first three years. Poster presented at Research Days, USUHS, Bethesda, Maryland.

Cox, D. W., Fullerton, C. S., Biggs, Q. M., McCarroll, J. E., Kansky, J., Stuppy, A., & Ursano, R. J. (November, 2012). Adapting and applying empirically-based principles for acute stress responses to the chronic stress responses of Mortuary Affairs Soldiers. Poster presented at the Association of Behavioral and Cognitive Therapies Annual Meeting, National Harbor, Maryland.

Cox, D. W., Fullerton, C. S., Biggs, Q. M., McCarroll, J. E., Stuppy, A., Kansky, J., & Ursano, R. J.

(April, 2012). Troop Educational for Army Morale (TEAM): A post deployment educational program for Mortuary Affairs Soldiers; results from the first two years. Poster presented at the 7th Annual Conference on Amygdala, Stress and PTSD: Recovery from Stress, USUHS, Bethesda, Maryland.

Fullerton, C. S., Benedek, D. M., Zatzick, D., McCarroll, J. E., Biggs, Q. M., Liu, X., Kansky, J., Stuppy, A., & Ursano, R. J. (September, 2012). Mortuary Affairs Soldiers: Early intervention and altering barriers to care for traumatic stress and PTSD. Oral presentation given at the Military Operational Medicine Research Program (MOMRP), Stigma/Overcoming Barriers to Care and Access Solutions, Fort Detrick, Maryland.

Fullerton, C. S., Ursano, R. J., Benedek, D. M., McCarroll, J. E., Biggs, Q. M., Zatzick, D. F., Newby, J. H., Kao, T. C., & Karpel, H. M. (September, 2009). Mortuary Affairs Soldiers: Early intervention and altering barriers to care for traumatic stress and PTSD. Poster presented at the Military Health Research Forum, Kansas City, Missouri.

Gray, C., Fullerton, C. S., Biggs, Q. M., McCarroll, J. E., Santiago, P., Newby, J. H., Riley, S. N., Kodsy, N. T., Spiegel, C. A., & Ursano, R. J. (August, 2011). Empirical evidence for a Psychological First Aid-based intervention in soldiers post-deployment. Poster presented at the American Psychological Association Annual Meeting, Washington District of Columbia.

Other Achievements

Nothing to report

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Appendices

Appendix A – Supplemental Tables and Figures

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Appendix A – Supplemental Tables and Figures

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A1. Frequency of Enrollments, Subjects in Analysis, and Assessments by Cohort

Frequency of Enrollments, Subjects in Analysis, and Assessments by Cohort

Study Participation	CH1	CH2	CH3	CH4	CH5	CH6	CH7	CH8	CH9	CH10	Total
Enrollments	21	31	23	12	3	4	11	12	12	6	135
Removed due to Being In A Prior Cohort				-1		-3	-2	-2		-1	-9
Removed due to Incomplete Participation				-1							-1
Subjects in Study Analysis	21	31	22	11	3	1	9	10	12	5	125

Assessments	CH1	CH2	CH3	CH4	CH5	CH6	CH7	CH8	CH9	CH10	Total
<i>Baseline Survey</i>											
Subjects in Study Analysis	21	31	22	11	3	1	9	10	12	5	125
"No" to Link of Baseline & Month 2 – 10 Surveys	-3	-2	-1	-2			-2	-2	-1	-1	-14
Did Not Complete A Baseline Survey	-2								-1		-3
Subjects with A Baseline Survey	16	29	21	9	3	1	7	8	10	4	108

<i>Month 2 – 10 Surveys</i>											
Subjects in Study Analysis	21	31	22	11	3	1	9	10	12	5	125
Did Not Complete Any Month 2 – 10 Surveys	-1	-7		-1		-1	-1		-1		-12
Subjects with One or More Month 2 – 10 Surveys	20	24	22	10	3	0	8	10	11	5	113

<i>Baseline Survey & Month 2 – 10 Surveys</i>											
Subjects in Study Analysis	21	31	22	11	3	1	9	10	12	5	125
Subjects with A Baseline <u>OR</u> One or More Month 2 – 10 Surveys	21	31	22	11	3	1	9	10	12	5	125
Did Not Complete <u>Either</u> A Baseline OR Any Month 2 – 10 Surveys	-6	-9	-1	-3		-1	-3	-2	-3	-1	-29
Subjects with A Baseline <u>AND</u> One or More Month 2 – 10 Surveys	15	22	21	8	3	0	6	8	9	4	96

CH = Cohort

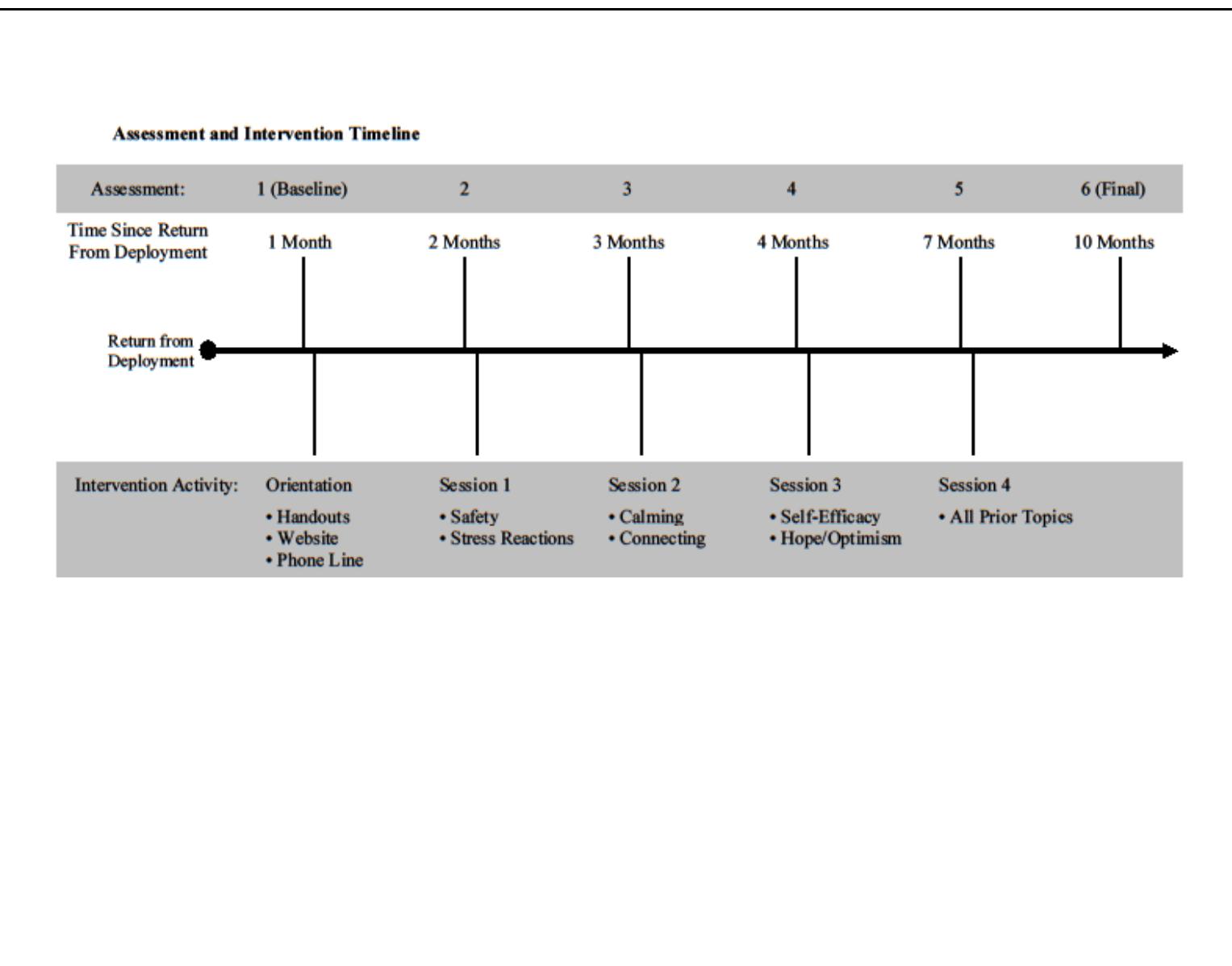
A2. Demographic Characteristic Comparison

Demographic Characteristics of All Subjects and Intervention versus Comparison Groups for Cohorts 1 – 10, N = 125

Demographic Characteristic	All (N = 125)† N (%)	Intervention (n = 67) N (%)	Comparison (n = 58) N (%)	t or χ^2	p
Age					
Mean (SD), years	28.1 (7.2)	28.6 (7.6)	27.6 (6.8)	.76	.45
Range	19-50	19-50	19-50		
Gender					
Male	85 (68.0)	44 (65.7)	41 (70.7)		
Female	40 (32.0)	23 (34.3)	16 (29.3)		
Race/Ethnicity					
White	72 (57.6)	35 (52.2)	37 (63.8)		
Non-White	53 (42.4)	32 (47.8)	21 (36.2)	1.70	.19
Education					
High School diploma/GED or less	56 (44.8)	30 (44.8)	26 (44.8)		
Some College/Tech School or more	69 (55.2)	37 (55.2)	32 (55.2)	.00	1.00
Married					
	78 (62.4)	38 (56.7)	40 (69.0)	1.99	.16
Live with Spouse					
	58 (46.4)	30 (44.8)	28 (48.3)	.15	.70
Live with Significant Other (N = 124)					
	8 (6.5)	5 (7.6)	3 (5.2)	.30	.59
Have Children (N = 108)					
	47 (43.5)	26 (44.8)	21 (42.0)	.09	.77
Rank					
E-1 to E-3	29 (23.2)	13 (19.4)	16 (27.6)		
E-4	71 (56.8)	39 (58.2)	32 (55.2)		
E-5 to E-8	23 (18.4)	14 (20.9)	9 (15.5)		
O-1 to O-3	2 (1.6)	1 (1.5)	1 (1.7)		
Spouse/Significant Other Active Duty Military (N = 107)					
	18 (16.8)	14 (24.1)	4 (8.2)	4.84	.03*

*p < .05; **p < .01; ***p < .001; †N = 125 unless specified; demographics are first available

A3. Assessment and Intervention Timeline

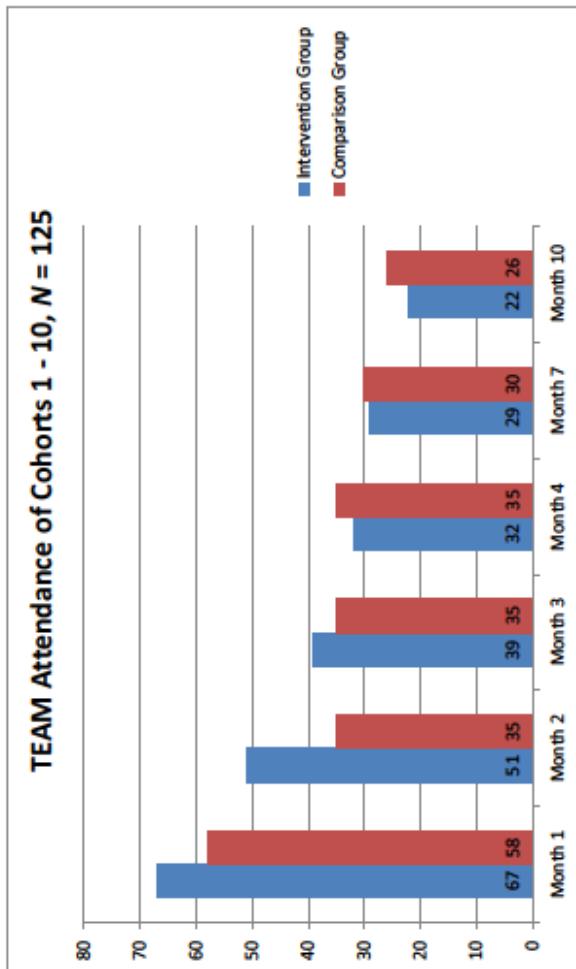


A4. Attendance Baseline through Final Survey

TEAM Attendance Baseline through Final Survey for Intervention & Comparison Groups, Cohorts 1 - 10, N = 125

	Cohort N	Group N	Baseline Attendance N	Session 1 Attendance N	Session 2 Attendance N	Session 3 Attendance N	Session 4 Attendance N	Final Survey Attendance N	Total N
Cohort 1	21	Intv = 11	11	11	5	6	8	3	44
		Cmp = 10	10	4	6	8	2	1	31
Cohort 2	31	Intv = 16	16	12	6	7	2	3	46
		Cmp = 15	15	7	9	7	7	5	50
Cohort 3	22	Intv = 12	12	8	8	6	4	4	42
		Cmp = 10	10	9	6	6	5	7	43
Cohort 4	11	Intv = 6	6	5	3	2	4	1	21
		Cmp = 5	5	2	3	2	3	1	16
Cohort 5	3	Intv = 2	2	1	2	2	2	2	11
		Cmp = 1	1	1	1	0	1	1	5
Cohort 6	1	Intv = 1	1	0	0	0	0	0	1
		Cmp = 0	0	0	0	0	0	0	0
Cohort 7	9	Intv = 5	5	2	3	2	1	1	14
		Cmp = 4	4	2	3	3	4	3	19
Cohort 8	10	Intv = 5	5	5	3	3	2	3	23
		Cmp = 5	5	4	3	4	2	4	22
Cohort 9	12	Intv = 6	6	4	4	2	3	3	22
		Cmp = 6	6	5	2	4	4	4	25
Cohort 10	5	Intv = 3	3	3	3	2	3	2	16
		Cmp = 2	2	1	2	1	2	0	8
Total	125	Intv = 67	67	51	39	32	29	22	240
		Cmp = 58	58	35	35	35	30	26	219

Intv = Intervention Group, Cmp = Comparison Group



A5. Number of Sessions Attended by the Intervention Group

Number of Sessions Attended by the Intervention Group, Cohorts 1 – 10, N = 67

Intervention Sessions Attended by the Intervention Group Months 2 - 7*

Number of Intervention Sessions Attended	N Attended	% Attended	Cumulative %
0	5	7.46	7.46
1	14	20.90	28.36
2	18	26.87	55.22
3	19	28.36	83.58
4	11	16.42	100.00

*Time period includes four 2-hour intervention sessions

Intervention and Assessment Sessions Attended by the Intervention Group Months 2 - 10**

Number of Intervention and Assessment Sessions Attended	N Attended	% Attended	Cumulative %
0	5	7.46	7.46
1	12	17.91	25.37
2	15	22.39	47.76
3	14	20.90	68.66
4	16	23.88	92.54
5	5	7.46	100.00

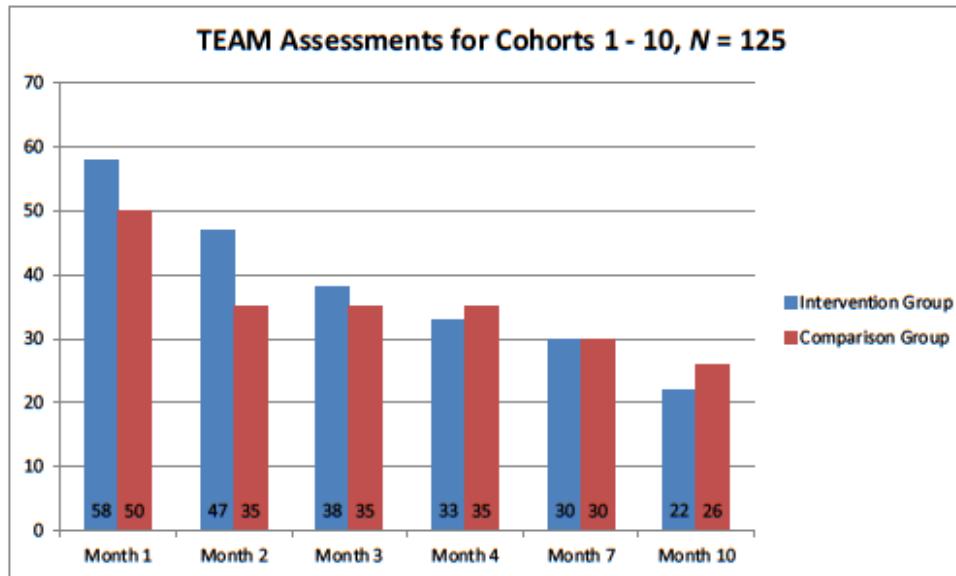
**Time period includes four 2-hour intervention sessions and the final survey

A6. Number of Assessments Baseline through Final Survey

TEAM Assessments Baseline through Final Survey for Intervention & Comparison Groups, Cohorts 1 - 10, N= 125

	Cohort N	Group N	Baseline Assessment N	Workshop 1 Assessment N	Workshop 2 Assessment N	Workshop 3 Assessment N	Workshop 4 Assessment N	Final Survey Assessment N	Total N
Cohort 1	21	Intv = 11	7	6	5	6	8	3	35
		Cmp = 10	9	4	6	8	2	1	30
Cohort 2	31	Intv = 16	16	12	6	7	3	3	47
		Cmp = 15	13	7	9	7	7	5	48
Cohort 3	22	Intv = 12	11	9	7	6	4	4	41
		Cmp = 10	10	9	6	6	5	7	43
Cohort 4	11	Intv = 6	5	5	3	2	4	1	20
		Cmp = 5	4	2	3	2	3	1	15
Cohort 5	3	Intv = 2	2	1	2	2	2	2	11
		Cmp = 1	1	1	1	0	1	1	5
Cohort 6	1	Intv = 1	1	0	0	0	0	0	1
		Cmp = 0	0	0	0	0	0	0	0
Cohort 7	9	Intv = 5	4	2	3	2	1	1	13
		Cmp = 4	3	2	3	3	4	3	18
Cohort 8	10	Intv = 5	4	5	5	3	2	3	22
		Cmp = 5	4	4	3	4	2	4	21
Cohort 9	12	Intv = 6	5	4	4	3	3	3	22
		Cmp = 6	5	5	2	4	4	4	24
Cohort 10	5	Intv = 3	3	3	3	2	3	2	16
		Cmp = 2	1	1	2	1	2	0	7
Total	125	Intv = 67	58	47	38	33	30	22	228
		Cmp = 58	50	35	35	35	30	26	211

Intv = Intervention Group, Cmp = Comparison Group



A7. Mixed Model Covariate Comparison

TEAM Mixed Model Comparisons, Baseline through Final Survey, Cohorts 1 – 10, N = 108

Model Comparisons		-2 Res Log Likelihood						
#	Covariate	PCL Total Score	PCL Intrusion	PCL Avoidance	PCL Arousal	PHQ	WHOQOL ENV	WHOQOL PSY
a.	No Covariates	3043.7	2167.2	2422.9	2290.1	2372.8	1612.3	1556.8
b.	Gender	3034.3	2160.7	2415.2	2283.8	2363.5	1608.7	1547.8
c.	Live with Spouse	3037.4	2163.5	2419.5	2285.2	2369.8	1609.1	1550.1
d.	Have Children	3034.8	2159.9	2417.2	2284.3	2366.8	1605.3	1549.8
e.	Leadership	3029.6	2158.0	2415.9	2276.1	2358.7	1610.3	1554.0
f.	Gender & Live with Spouse	3026.9	2156.2	2411.0	2277.9	2359.6	1605.1	1539.1
g1.	Gender & Have Children	3023.7	2151.7	2408.1	2276.7	2355.7	1600.8	1538.6
g2.	Gender & Have Children & Interaction Treatment/Have Children	3018.6	2149.0	2404.9	2273.1	2352.0	1595.6	1535.6
h.	Gender & Leadership	3019.2	2150.7	2407.6	2268.9	2347.9	1606.5	1544.3
i.	Live with Spouse & Have Children	3030.5	2158.2	2415.0	2281.4	2364.7	1603.4	1546.2
j.	Live with Spouse & Leadership	3025.4	2156.1	2413.8	2273.7	2356.8	1608.0	1549.2
k.	Have Children & Leadership	3022.8	2152.8	2411.8	2272.3	2354.6	1604.6	1548.4

N = 108 is the effective sample (N = 125 – 17 subjects with no score for “Have Children”); values in green are the lowest, values in yellow are not significantly different from the lowest, and circled values are the selected models

A8. Mixed Model of the PCL-17 Intrusion Subscale

Parameter Estimates of the Longitudinal Mixed Model on PCL-17 Intrusion Subscale Score with Gender, Have Children, and the Interaction of Treatment & Have Children as Covariates (N = 108)

Independent Variable	Estimate	SE	t or z	p
Fixed effects				
Intercept	9.1***	0.8	11.11	<.001
Month 1 (reference point)	--	--	--	--
Month 2	0.1	0.5	0.24	.81
Month 3	-0.7	0.7	-1.03	.31
Month 4	0.4	0.8	0.47	.64
Month 7	-0.6	1.1	-0.53	.60
Month 10	-1.8	1.2	-1.53	.13
Treatment	-0.6	1.1	-0.49	.62
Month 1*treatment	--	--	--	--
Month 2*treatment	0.5	0.7	0.69	.49
Month 3*treatment	2.1*	1.0	2.20	.03
Month 4*treatment	-0.6	1.1	-0.51	.61
Month 7*treatment	-0.7	1.5	-0.49	.62
Month 10*treatment	-0.3	1.6	-0.18	.86
Female (centered)	2.0*	0.8	2.57	.01
Have children (centered)	1.8	1.1	1.69	.09
Interaction of treatment & have children (centered)	0.4	1.5	0.29	.77
Random effects				
Spatial power	0.8***	<0.1	27.96	<.001
Residual	23.4***	2.2	10.48	<.001
Model chi-square	157.54***	--	--	<.001

*p <.05; **p <.01; ***p <.001; Estimate = parameter estimate, SE = standard error

Type 3 Tests of Fixed Effects for PCL-17 Intrusion Subscale Score (N=108)

Effect	F	p
Time	1.71	.13
Treatment	0.05	.82
Time*treatment	2.44*	.04
Female (centered)	6.60*	.01
Have children (centered)	7.70**	<.01
Interaction treatment & have children (centered)	0.08	.77

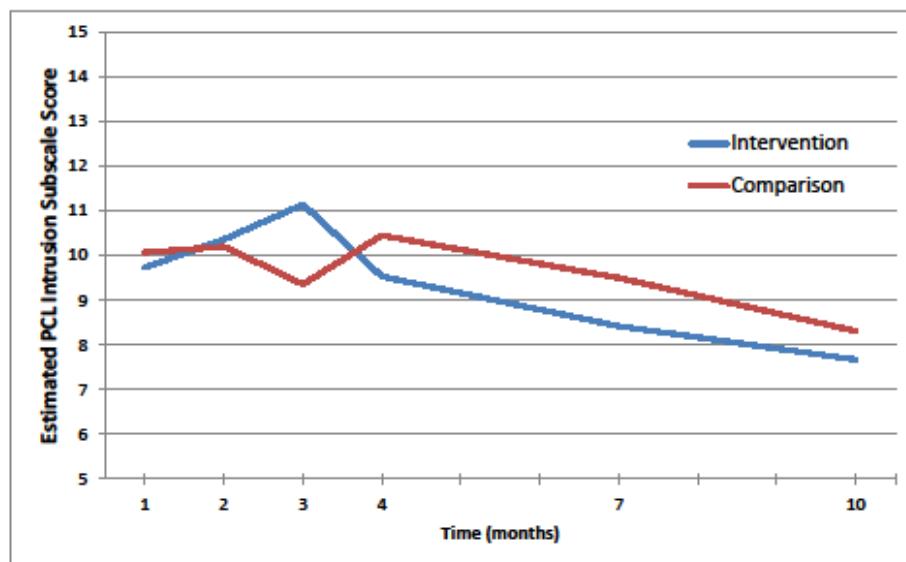
*p < .05; **p < .01; ***p < .001

Predicted Least Squares Means of PCL-17 Intrusion Subscale Score and Significance Tests on Differences in Mean for Intervention and Comparison Groups at Six Time Points ($N = 108$)

Time Point	Intervention		Comparison		<i>ED</i>	<i>SE</i>	<i>t</i>	<i>p</i>
	Mean	<i>SE</i>	Mean	<i>SE</i>				
Month 1	9.7	0.6	10.1	0.7	-0.3	0.9	-0.36	.72
Month 2	10.4	0.7	10.2	0.7	0.2	1.0	0.16	.87
Month 3	11.1	0.7	9.4	0.8	1.8	1.1	1.68	.09
Month 4	9.5	0.8	10.5	0.8	-0.9	1.1	-0.82	.41
Month 7	8.4	0.9	9.5	1.0	-1.1	1.3	-0.81	.42
Month 10	7.7	1.0	8.3	1.0	-0.6	1.4	-0.45	.65

* $p < .05$; ** $p < .01$; *** $p < .001$; *SE* = standard error; *ED* = estimated difference

Longitudinal Trajectories of PCL-17 Intrusion Subscale Score for Intervention and Comparison Groups with Gender, Have Children, and the Interaction of Treatment & Have Children as Covariates (N = 108)



A9. Mixed Model of the PCL-17 Avoidance Subscale

Parameter Estimates of the Longitudinal Mixed Model on PCL-17 Avoidance Subscale Score with Gender, Have Children, and the Interaction of Treatment & Have Children as Covariates (N = 108)

Independent Variable	Estimate	SE	t or z	p
Fixed effects				
Intercept	12.8***	1.1	11.66	<.001
Month 1 (reference point)	--	--	--	--
Month 2	-0.1	0.8	-0.02	.98
Month 3	-0.1	1.0	-0.08	.93
Month 4	0.9	1.2	0.79	.43
Month 7	-0.8	1.5	-0.56	.57
Month 10	-2.7	1.6	-1.69	.09
Treatment	-1.0	1.5	-0.69	.49
Month 1*treatment	--	--	--	--
Month 2*treatment	1.8	1.1	1.67	.10
Month 3*treatment	3.0*	1.4	2.14	.03
Month 4*treatment	0.5	1.6	0.33	.74
Month 7*treatment	0.3	2.1	0.14	.89
Month 10*treatment	1.5	2.3	0.67	.50
Female (centered)	2.8**	1.0	2.72	<.01
Have children (centered)	2.4	1.4	1.67	.10
Interaction of treatment & have children (centered)	-0.3	1.9	-0.13	.89
Random effects				
Spatial power	0.7***	<0.1	23.52	<.001
Residual	42.5***	3.9	10.91	<.001
Model chi-square	136.4***	--	--	<.001

*p <.05; **p <.01; ***p <.001; Estimate = parameter estimate, SE = standard error

Type 3 Tests of Fixed Effects for PCL-17 Avoidance Subscale Score (N=108)

Effect	F	p
Time	2.19	.06
Treatment	0.00	.99
Time*treatment	1.47	.20
Female (centered)	7.38**	<.01
Have children (centered)	5.38*	.02
Interaction treatment & have children (centered)	0.02	.89

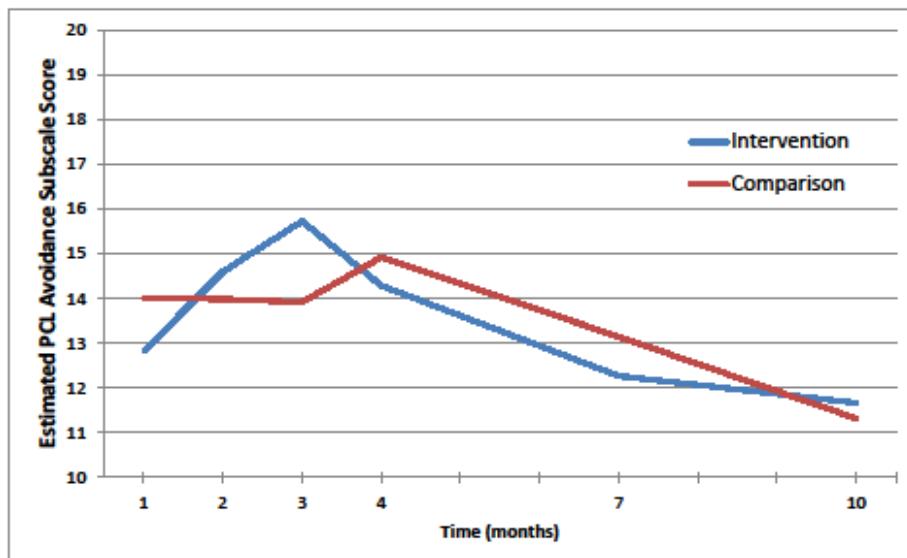
*p <.05; **p <.01; ***p <.001

**Predicted Least Squares Means of PCL-17 Avoidance Subscale Score and Significance
Tests on Differences in Mean for Intervention and Comparison Groups at Six Time Points
(N = 108)**

Time Point	Intervention		Comparison		<i>ED</i>	<i>SE</i>	<i>t</i>	<i>p</i>
	Mean	<i>SE</i>	Mean	<i>SE</i>				
Month 1	12.8	0.9	14.0	0.9	-1.2	1.3	-0.92	.36
Month 2	14.6	0.9	14.0	1.0	0.6	1.4	0.44	.66
Month 3	15.7	1.0	13.9	1.0	1.8	1.4	1.25	.21
Month 4	14.3	1.1	14.9	1.1	-0.6	1.5	-0.41	.68
Month 7	12.3	1.3	13.2	1.3	-0.9	1.8	-0.48	.63
Month 10	11.7	1.4	11.3	1.3	0.3	1.9	0.18	.86

p* < .05; *p* < .01; ****p* < .001; *SE* = standard error; *ED* = estimated difference

Longitudinal Trajectories of PCL-17 Avoidance Subscale Score for Intervention and Comparison Groups with Gender, Have Children, and the Interaction of Treatment & Have Children as Covariates (N=108)



A10. Mixed Model of the PCL-17 Hyperarousal Subscale

Parameter Estimates of the Longitudinal Mixed Model on PCL-17 Hyperarousal Subscale Score with Gender, Have Children, and the Interaction of Treatment & Have Children as Covariates (N = 108)

Independent Variable	Estimate	SE	t or z	p
Fixed effects				
Intercept	12.1***	1.0	12.19	<.001
Month 1 (reference point)	--	--	--	--
Month 2	-1.1	0.6	-1.84	.07
Month 3	-1.0	0.8	-1.29	.20
Month 4	<0.1	0.9	0.03	.97
Month 7	-1.6	1.3	-1.23	.22
Month 10	-3.2*	1.4	-2.36	.02
Treatment	-1.5	1.4	-1.12	.27
Month 1*treatment	--	--	--	--
Month 2*treatment	1.7*	0.8	2.02	.04
Month 3*treatment	2.2*	1.1	1.99	.04
Month 4*treatment	-0.2	1.3	-0.16	.87
Month 7*treatment	0.2	1.8	0.11	.91
Month 10*treatment	2.0	2.0	1.03	.30
Female (centered)	2.2*	1.0	2.27	.03
Have children (centered)	1.3	1.3	0.99	.33
Interaction of treatment & have children (centered)	1.5	1.8	0.81	.42
Random effects				
Spatial power	0.8***	<0.1	30.71	<.001
Residual	34.0***	3.3	10.27	<.001
Model chi-square	169.6***	--	--	<.001

*p <.05; **p <.01; ***p <.001; Estimate = parameter estimate, SE = standard error

Type 3 Tests of Fixed Effects for PCL-17 Hyperarousal Subscale Score (N = 108)

Effect	F	p
Time	1.47	.20
Treatment	0.04	.84
Time*treatment	2.11	.06
Female (centered)	5.15*	.03
Have children (centered)	5.14*	.03
Interaction treatment & have children (centered)	0.66	.42

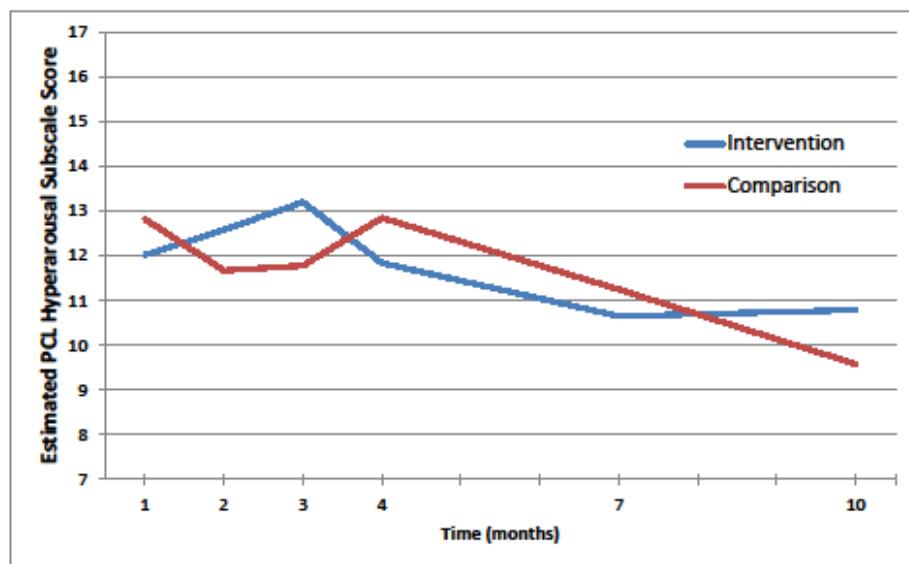
*p <.05; **p <.01; ***p <.001

Predicted Least Squares Means of PCL-17 Hyperarousal Subscale Score and Significance Tests on Differences in Mean for Intervention and Comparison Groups at Six Time Points (N = 108)

Time Point	Intervention		Comparison		<i>ED</i>	<i>SE</i>	<i>t</i>	<i>p</i>
	Mean	<i>SE</i>	Mean	<i>SE</i>				
Month 1	12.0	0.8	12.8	0.8	-0.8	1.1	-0.71	.48
Month 2	12.6	0.8	11.7	0.9	0.9	1.2	0.75	.45
Month 3	13.2	0.9	11.8	0.9	1.4	1.3	1.13	.26
Month 4	11.8	0.9	12.8	1.0	-1.0	1.3	-0.76	.45
Month 7	10.6	1.1	11.3	1.1	-0.6	1.6	-0.38	.70
Month 10	10.8	1.2	9.6	1.2	1.2	1.7	0.71	.48

p* < .05; *p* < .01; ****p* < .001; *SE* = standard error; *ED* = estimated difference

Longitudinal Trajectories of PCL-17 Hyperarousal Subscale Score for Intervention and Comparison Groups with Gender, Have Children, and the Interaction of Treatment & Have Children as Covariates (N = 108)



A11. Mixed Model of the WHOQOL Psychological Subscale

Parameter Estimates of the Longitudinal Mixed Model on WHOQOL Psychological Subscale with Gender, Have Children, and the Interaction of Treatment & Have Children as Covariates (N = 96)

Independent Variable	Estimate	SE	t or z	p
Fixed effects				
Intercept	24.9***	1.1	22.84	<.001
Month 2	-1.8	1.1	-1.59	.11
Month 3	-0.9	1.1	-0.86	.39
Month 4	-1.3	1.1	-1.21	.23
Month 7	0.1	1.0	0.14	.89
Month 10 (reference point)	--	--	--	--
Treatment	-0.9	1.6	-0.54	.59
Month 2*treatment	-0.1	1.6	-0.05	.96
Month 3*treatment	-1.2	1.6	-0.73	.46
Month 4*treatment	<-0.1	1.6	-0.01	.99
Month 7*treatment	-1.1	1.5	-0.78	.44
Month 10*treatment	--	--	--	--
Female (centered)	-2.9**	0.9	-3.14	<.01
Have children (centered)	-2.6*	1.3	-2.11	.04
Interaction of treatment & have children (centered)	0.5	1.7	0.31	.76
Random effects				
Spatial power	0.8***	<0.1	31.72	<.001
Residual	23.4***	2.6	8.97	<.001
Model chi-square	120.62***	--	--	<.001

* $p < .05$; ** $p < .01$; *** $p < .001$; Estimate = parameter estimate, SE = standard error, WHOQOL is not included in Month 1 assessment

Type 3 Tests of Fixed Effects for WHOQOL Psychological Subscale Total Score (N = 96)

Effect	F	p
Time	1.52	.20
Treatment	1.58	.21
Time*treatment	1.04	.39
Female (centered)	9.85**	<.01
Have children (centered)	7.90**	<.01
Interaction of treatment & have children (centered)	0.10	.76

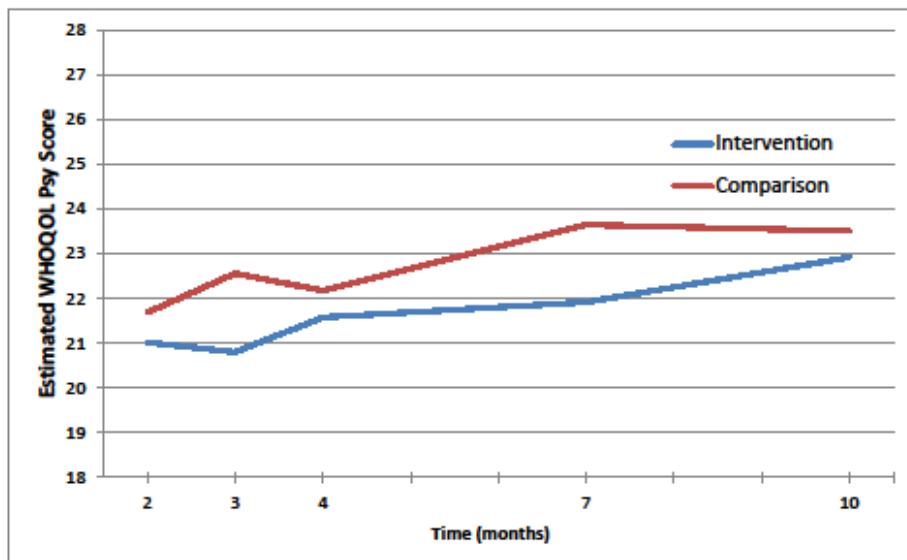
*p < .05; **p < .01; ***p < .001

Predicted Least Squares Means of WHOQOL Psychological Subscale Total Score and Significance Tests on Differences in Mean for Intervention and Comparison Groups at Five Time Points (N = 96)

Time Point	Intervention		Comparison		<i>ED</i>	<i>SE</i>	<i>t</i>	<i>p</i>
	Mean	<i>SE</i>	Mean	<i>SE</i>				
Month 2	21.0	0.7	21.7	0.8	-0.7	1.1	-0.63	.53
Month 3	20.8	0.7	22.6	0.8	-1.8	1.1	-1.63	.10
Month 4	21.6	0.8	22.2	0.8	-0.6	1.1	-0.54	.59
Month 7	21.9	0.9	23.6	0.9	-1.7	1.3	-1.33	.18
Month 10	22.9	1.0	23.5	1.0	-0.6	1.4	-0.42	.67

p* < .05; *p* < .01; ****p* < .001; *SE* = standard error; *ED* = estimated difference; WHOQOL is not included in Month 1 assessment; higher scores indicate better functioning

Longitudinal Trajectories of WHOQOL Psychological Subscale Score for Intervention and Comparison Groups with Gender, Have Children, and the Interaction of Treatment & Have Children as Covariates (N=96)



WHOQOL is not included in Month 1 assessment; higher scores indicate better functioning
Appendix A12

A12. Mixed Model of the WHOQOL Environmental Subscale

Parameter Estimates of the Longitudinal Mixed Model on WHOQOL Environmental Subscale with Gender, Have Children, and the Interaction of Treatment & Have Children as Covariates (N = 96)

Independent Variable	Estimate	SE	t or z	p
Fixed effects				
Intercept	32.8***	1.2	27.42	<.001
Month 2	-1.4	1.3	-1.06	.29
Month 3	-1.3	1.2	-1.04	.30
Month 4	-1.3	1.2	-1.04	.30
Month 7	0.4	1.1	0.38	.70
Month 10 (reference point)	--	--	--	--
Treatment	-1.9	1.7	-1.09	.28
Month 2*treatment	-0.2	1.8	-0.09	.93
Month 3*treatment	-0.4	1.8	-0.22	.83
Month 4*treatment	-0.3	1.8	-0.16	.87
Month 7*treatment	-1.8	1.7	-1.11	.27
Month 10*treatment	--	--	--	--
Female (centered)	-1.8	1.0	-1.87	.06
Have children (centered)	-3.8**	1.4	-2.82	<.01
Interaction of treatment & have children (centered)	2.7	1.8	1.48	.14
Random effects				
Spatial power	0.8***	<0.1	28.65	<.001
Residual	28.1***	3.1	9.09	<.001
Model chi-square	123.2***	--	--	<.001

* $p < .05$; ** $p < .01$; *** $p < .001$; Estimate = parameter estimate, SE = standard error, WHOQOL is not included in Month 1 assessment

Type 3 Tests of Fixed Effects for WHOQOL Environmental Subscale Total Score (N= 96)

Effect	F	p
Time	0.84	.50
Treatment	1.39	.24
Time*treatment	0.44	.78
Female (centered)	3.51	.06
Have children (centered)	7.26**	<.01
Interaction of treatment & have children (centered)	2.18	.14

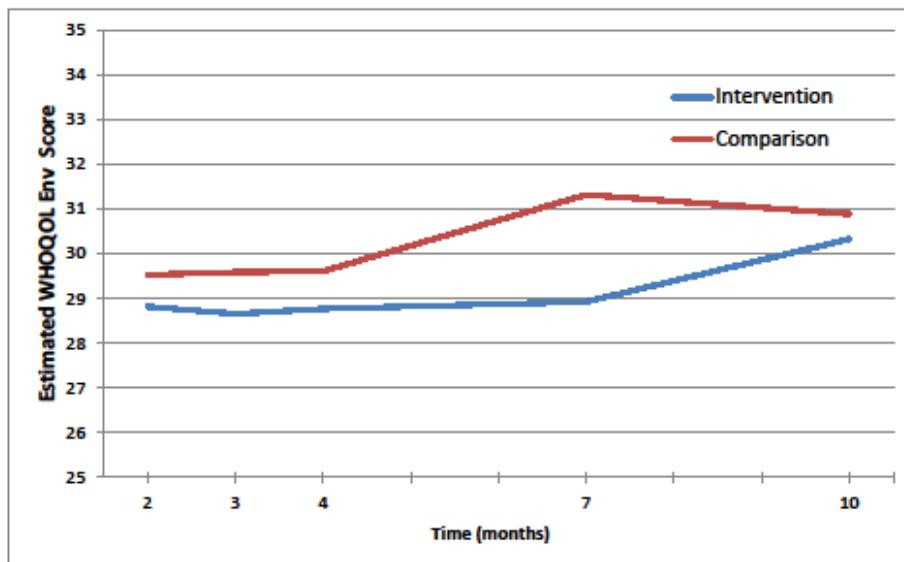
* $p < .05$; ** $p < .01$; *** $p < .001$

Predicted Least Squares Means of WHOQOL Environmental Subscale Total Score and Significance Tests on Differences in Mean for Intervention and Comparison Groups at Five Time Points (N = 96)

Time Point	Intervention		Comparison		<i>ED</i>	<i>SE</i>	<i>t</i>	<i>p</i>
	Mean	<i>SE</i>	Mean	<i>SE</i>				
Month 2	28.8	0.8	29.5	0.9	-0.7	1.2	-0.61	.55
Month 3	28.7	0.8	29.6	0.9	-0.9	1.2	-0.79	.43
Month 4	28.8	0.9	29.6	0.9	-0.8	1.2	-0.69	.49
Month 7	28.9	1.0	31.3	1.0	-2.4	1.4	-1.66	.10
Month 10	30.3	1.1	30.9	1.1	-0.6	1.5	-0.36	.72

p* < .05; *p* < .01; ****p* < .001; *SE* = standard error; *ED* = estimated difference; WHOQOL is not included in Month 1 assessment; higher scores indicate better functioning

Longitudinal Trajectories of WHOQOL Environmental Subscale Score for Intervention and Comparison Groups with Gender, Have Children, and the Interaction of Treatment & Have Children as Covariates (N=96)



WHOQOL is not included in Month 1 assessment; higher scores indicate better functioning

A13. Significance Values of Type 3 Tests of Fixed Effects for All Outcome Measures

Significance Values of the Mixed Model Type 3 Tests of Fixed Effects of the Outcome Measures, Cohorts 1-10, N = 108

Fixed Effect	PCL Total Score	PCL Intrusion Subscale	PCL Avoidance Subscale	PCL Arousal Subscale	PHQ Total Score	WHOQOL ENV Subscale	WHOQOL PSY Subscale
Mixed Model Gender & Have Children & Interaction Treatment/Have Children Significance Values (p)							
Time	.07	.13	.06	.20	—	.50	.20
Treatment	.94	.82	.99	.84	—	.24	.21
Time*Treatment	.03*	.04*	.20	.06	—	.78	.39
Female (centered)	<.01**	.01*	<.01**	.03*	—	.06	<.01**
Have Children (centered)	.01*	<.01**	.02*	.03*	—	<.01**	<.01**
Interaction Treatment/Have Children	.71	.77	.89	.42	—	.14	.76
Mixed Model Gender & Leadership Significance Values (p)							
Time	—	—	—	—	.05	—	—
Treatment	—	—	—	—	.67	—	—
Time*Treatment	—	—	—	—	.71	—	—
Female (centered)	—	—	—	—	<.01**	—	—
Leadership (centered)	—	—	—	—	<.001***	—	—

p <.05; * p <.01; ** p <.001; PCL = PTSD Checklist 17, PHQ = Patient Health Questionnaire 9, WHOQOL = World Health Organization Quality of Life, ENV = Environmental, PSY = Psychological

Appendix B – Intervention Session Information

B1. Description of the Intervention Sessions

B2. Intervention Handbook for Instructors

B1. Description of the Intervention Sessions

The TEAM intervention material was presented in four 2-hour sessions held at 2, 3, 4 and 7 months post deployment. The sessions were typically conducted by two trained psychologists or psychiatrists who served as facilitators plus one or more research assistants. A variety of methods was used to present intervention material including group discussion, role-plays, and video clips, which illustrated teaching points.

Sessions 1, 2 and 3 (held at 2, 3 and 4 months post deployment) each covered new intervention material. Session 4 (held at 7 months post deployment) was a booster session, a review of the content covered in sessions 1 through 3.

Session 1. The goals of session 1 included helping participants understand stress responses, the overall concepts of the principles of PFA, and the details of the first principle of PFA, safety. The activities consisted of a group discussion facilitated by TEAM leaders and a video clip. Participants identified life events that are commonly perceived to be stressful (described in terms of “*difficult events*”). Participants watched a humorous animated video clip of a character responding to stress and then discussed common reactions to difficult events. This was followed by a discussion of triggers for ongoing responses (particularly maladaptive responses) to past difficult events and methods of coping with difficult events. The principle of safety was discussed as covering both physical safety (i.e., practical activities that keep one safe such as wearing a seatbelt in an automobile) and emotional safety (i.e., managing perceptions of threat). TEAM leaders also presented a brief orientation to the relationship of thoughts, feelings, and actions (behaviors) based on principles of cognitive behavioral therapy.

Session 2. The second and third principles of PFA, calming and connecting, were presented and discussed in session 2. The goals of the session were to help participants improve

their ability to become calm and connect with others for support. The importance and benefits of calming were discussed and then a TEAM leader led a calming exercise consisting of deep diaphragmatic breathing and progressive muscle relaxation. This was followed by a discussion of various relaxation techniques including ones that employ imagery and meditation. Connecting was presented as the importance of maintaining contact, meaningful interactions, and support with individuals as well as helping organizations. The connecting discussion included two humorous animated video clips of a character attempting to connect and support another individual. This was followed by a discussion of how one can recognize when others need help/support (buddy care, spouse care) and a role-play exercise exploring ways one can provide help/support either by personally taking action or by obtaining assistance from others.

Session 3. The fourth and fifth principles of PFA, self-efficacy and hope/optimism, were presented and discussed in session 3. The goals of the session were to help participants recognize and utilize past successes to foster and maintain a belief in one's ability to overcome difficulties and achieve a positive future. A four-step approach to problem solving was discussed and reinforced with a video clip portraying a group of individuals who used problem solving skills and self- and group-efficacy to overcome significant problems. The role of positive thoughts and a hopeful outlook in overcoming difficult events was then discussed and reinforced with a video clip of two men, one with an abundance of hope and one without, who must deal with similar adversity. The relationship of thoughts, feelings, and actions (behaviors), based on cognitive behavioral therapy, was then explored particularly as it relates to how thoughts and actions can be used to affect negative emotions and mood. Finally, to reinforce the principle of calming discussed in session 2, a calming exercise was practiced.

Session 4. The goals of session 4, the final session, were to review the main points of each PFA principle in order to reinforce the learning and integration of the principles for participants who had attended the prior sessions as well as to present the material for the first time to participants who had missed a prior session. Session 4 included group discussions, a role-play exercise, and a final calming exercise.

B2. Intervention Handbook for Instructors

Early Intervention and Altering Barriers to Care for Traumatic Stress and PTSD

Soldier Educational Intervention Handbook For Instructors

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Appendix B - Intervention Session Information 08 QB - DONE 1MB

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TERMS

Intervention Group = Workshop Group

Comparison Group = Usual Services Group

WORKSHOP TIMES

The timing of events listed below are approximate:

Recruitment/Orientation - 1 month post deployment

Workshop 1 - 2 months post deployment

Workshop 2 - 3 months post deployment

Workshop 3 - 4 months post deployment

Workshop 4 - 7 months post deployment

Final Survey (no intervention) - 10 months post deployment

RECRUITMENT/ORIENTATION

(Approximately 1 month post deployment)

Outline

FIRST HOUR

- A. Ongoing MA Survey
- B. Break

SECOND HOUR

- A. Introduction of Research Team
- B. Recruitment and Informed Consent (no leaders/command will be present)
 - Soldiers not participating in study are excused →
 - Participating subjects complete Informed Consent
 - Break
- C. Randomization to Usual Services Group or Workshop Group
 - Perform randomization procedure
 - Distribute: *Letter for Soldiers to Give to Command*
 - Complete: *Contact Information Card*
- D. Discuss Usual Services (Resources on and off Fort Lee)
 - Usual Services Group is excused →
- E. Description of TEAM Program Services
 - Workshops and Handouts
 - Web site, email and telephone information services
- F. Discuss/Distribute:: *Letter of Introduction to Spouses* and *Childcare Services*
- G. Brief training for Workshop Group
 - Principles of Psychological First Aid
 - First PFA Principle: Safety

Introduction

Good morning/afternoon, my name is _____ and I am joined by _____, _____, and _____. We are from the Center for the Study of Traumatic Stress at the Uniformed Services University School of Medicine. Many of you have already met Dr. McCarroll during his previous visits with you before or after your deployments. We have learned a great deal from you about the nature of your mission, about the challenges you face during deployment and the challenges and concerns you must address when you come back home.

*******Provider instruction:** Respectfully ask Officers to step out (leave) during the consent process →

Who is considered an officer/senior leader? Where do they go? What do they do? Do they do their own consent process?

Recruitment, Consent and Randomization

Overview of the TEAM Program

We are here to talk to you today about an educational training and resource program that we developed using the knowledge and experiences you have shared with our team. The program is based on the concept of Psychological First Aid (PFA), a set of recommended principles developed by the National Center for PTSD, the National Child Traumatic Stress Network and others for assisting people after disasters and other traumatic events. We have adapted the PFA principles to make them applicable to Soldiers and their spouses in dealing with adjustments associated with the return from deployment. PFA emphasizes five concepts: Safety, Calming, Connectedness, Self-efficacy and Hope/Optimism.

The education and training program combines a series of three workshops, one per month and a booster workshop at seven months, which will review all the material covered. To augment this training there is a series of web site resources as well as an email service and a toll-free telephone information line that are staffed by our team members to assist you with questions. With your agreement, the education and training program will also be offered to your spouses. Spouses will have the opportunity to attend their own training and booster workshops and have access to the on-line materials, email service and toll-free telephone information line.

All participants will be randomly assigned to one of two groups: Usual Services Group or Workshop Group. The Usual Services Group will continue to receive the usual services that are available here at Fort Lee and through the Army healthcare system. The Workshop Group will also receive the usual services, but will have the additional three half-day workshops; booster workshop at 7 months; access to the web site, email service, and toll-free telephone information line; and the opportunity for the spouse to participate in their own program.

Since this is a research project, everyone who volunteers will be asked to fill out brief surveys about the types of personal and health challenges they face on return from deployment. Participants in the Workshop Group will have a few additional questions about the helpfulness of the workshops, the web-based information, email service and the toll-free telephone information line in terms of addressing these challenges. The surveys will be similar to the surveys some of

you may have previously completed for Dr. McCarroll and are to take place at approximately 2, 3, 4, 7 and 10 months from the date of your return to the States. If you volunteer for this study, we will ask you if we can review your responses to the prior surveys, so that we don't have to ask you the same questions all over again. To maintain confidentiality, we will use the same non-identifying code to match the surveys in this study to your prior surveys.

This program is not mandatory. Participation in this educational program is completely voluntary and you may withdraw from participation at any time. Your Command will arrange for you to be available for the workshops. We will not notify Command of your actions except in cases where an individual expresses the intent to harm him- or herself or others. In such cases, Command and the Authorities may be notified and, if applicable, the threatened individual will be notified.

This program, based on the principles of Psychological First Aid and the knowledge and experiences you have shared with us, may help you and your family gain knowledge and skills to better adapt to your return home, and to help you through times of adversity that you may face in the future. This study will help us learn more about the consequences of deployment return to the home environment.

We will now distribute the consent form that describes the study, go over it in detail with you and then discuss any questions you may have. When you receive the consent form, please read through it.

*******Provider instruction:** Distribute consent forms and describe what informed consent is (e.g., participant rights, protection, what participants will/will not get out of the study). Spend enough time so that all questions are answered to the satisfaction of the prospective participants.

We are going to take 10-15 minutes for you to read the consent form, ask us any questions you may have and take a snack and bathroom break. We will be happy to talk with you individually if you have questions. If you are interested in participating, please sign the consent form, take a short break and return here so we can determine which group you will be in and provide you with further information. For those of you who are not going to participate, we appreciate your time. You are welcome to leave now and we wish you the best of luck.

*******Provider instruction:**

- Give participants about 10-15 minutes to review consent form and take a break

- Non-participants are excused →
- Collect signed consent forms and photocopy them
- Give a copy of the signed consent form back to the Soldier for them to keep
- Give the Soldier a TEAM folder for his/her papers and handouts

Randomization to Usual Services Group or Workshop Group

Welcome to the TEAM education program! We are now going to go through a process in which you will be randomly assigned to one of the two groups, the Usual Services Group or the Workshop Group. Random assignment means that none of us, neither you nor I nor anyone else, will have any influence on whether a person is assigned to one group or the other.

*******Provider instruction: Randomization Procedure:** Prior to recruitment the research investigators use the following method of randomizing subjects into 2 groups anticipating a maximum of 70 Soldiers will agree to participate in the study. We will use the first 4 digits of the serial number on a dollar bill to determine row and column to enter a random number table. We will then move across each row taking 2 digit numbers that are between 01 and 70, recording them and then dropping down to the next row on the random number table and continuing across until we have a list of 35 distinct 2 digit numbers. Then, after recruitment we will have all Soldiers who agree to participate through the consent process (see above) go around the room calling off a consecutive number until all Soldiers have a number (numbers will range from 01 to a maximum of 70 depending on how many participants have enrolled in the study. Then we will call off the first 35 random numbers selected prior to recruitment (these numbers are entirely random in their order since they derived directly from the random number table, which was entered at random. All participants whose number was called will be assigned into the intervention group and the remaining Soldiers will be in the usual services group. If there are an odd number of Soldiers who enrolled in the study, the intervention group will have the additional participant as numbers are assigned in the random manner described above

Okay, now you know whether you are in the Usual Services Group or the Workshop Group. Participants in both groups will receive surveys at approximately 2, 3, 4, 7 and 10 months from the date of return to the States. Participants in both groups will also continue to receive the usual services available at Fort Lee and through the Army healthcare system. However, the Workshop Group will have the additional services of PFA training and booster workshops; access to the

web site, email service and toll-free telephone information line; and the spouse training program.

We believe that the TEAM education and training program will be helpful and we wish that we could offer it to everyone. However, to confirm that it is truly helpful we must compare the outcomes of those who receive the training to those who don't receive the training. If the TEAM training is shown to help, it can then be given to other Soldiers and their families to help them address their post deployment challenges and concerns. We want to emphasize that regardless of whether you are assigned to the Usual Services Group or the Workshop Group, your participation in establishing the effectiveness of the TEAM program is very important and appreciated.

Letter for Soldier to Give to Command

*******Provider instruction:** Distribute handout: *Letter for Soldier to Give to Command*

We have a letter for you to sign and give to your Command informing them of your participation in this study.

Contact Information Cards

*******Provider instruction:** Distribute the *Contact Information Card*

We are passing out a *Contact Information Card* for you to fill out. We would like to be able to contact you in case something happens or you are unable to attend one of the upcoming workshops. For those of you in the Usual Services Group, please fill out only your contact information; you do not need to fill out the spouse section. For those of you in the Workshop Group, please fill out your contact information and if you are okay with us inviting your spouse to participate in the spouses' training program, fill in your spouse's contact information too.

*******Provider instruction:** Collect all *Contact Information Cards*

Separate the Usual Services Group and the Workshop Group

Resource List, Wallet Cards and Usual Services

*******Provider instruction:** Distribute handouts: *Resource at Fort Lee* and *Wallet Card*
(Note: the Resource lists and Wallet cards are different for the Workshop Group and
Usual Services Group)

We are distributing a handout titled, “*Resources at Fort Lee*” and a *Wallet Card*. The handout is a list of support resources that are currently available to you. It has phone numbers to emergency and non-emergency services; hospitals and other health care facilities; behavioral and financial counseling; crisis lines; community services in Hopewell; taxi services for the Fort Lee region; and several web sites related to healthcare and the military. We want you to be aware of the healthcare resources available to you, your spouse and children, and to have these phone and web site resources at hand should you or your family want to use them. We encourage you to put this handout on your fridge or some other place where it is readily available. We took some of the most useful phone numbers from the resource list and put them on a *Wallet Card*. We hope you will carry this card in your wallet or purse just in case you need to use any of these healthcare services.

We want to review the usual services that are currently available to you. We are going to talk about three resources: Army Community Services, Kenner Army Health Clinic and John Randolph Medical Center.

Army Community Services (ACS) at Fort Lee consists of a number of useful programs including a Financial Readiness Program to help military families with budgeting, banking, debt, large purchases, etc., and a New Parent Support program offering training, story hour and play group. Other ACS programs provide assistance with employment, relocation and special education needs. ACS can also direct you to local resources and crisis services. ACS is open from 8 a.m. - 5 p.m. and can be reached at (804) 734-6388 or (800) 507-7464; these numbers are on your resource handout. When calling for services ask for Information and Referral. They will direct you to one of the ACS groups or to another resource and provide logistical information and directions.

Some Soldiers who return from deployment experience problems that can be helped by behavioral health or social work counseling or substance abuse programs.

Kenner Army Health Clinic offers behavioral health and social work services, alcohol and substance abuse programs and other services. Kenner Army Health Clinic states their hours as 6:45 a.m. to 6:00 p.m., although some services open later or close earlier than these hours. It is best to call ahead to ensure that the department you want is open. Kenner's main phone number is (804) 734-9000 and the appointment line is (866) 645-4584 (these numbers are on your handout). If you are looking for Behavioral Health services, the clinic hours are 7:30 a.m. to 4:30 p.m. and walk in hours are 8:00 a.m. to 10 a.m. If you need help outside of these hours, the on-call doctor can be paged. During an initial Behavioral Health visit, you can expect to provide your ID card, which shows that you are in the DEERS (Defense Enrollment Eligibility Reporting System), complete an intake packet and go through a triage process. Active duty member information is kept anonymous unless a member requires hospitalization, in which case the clinic is obligated to inform Command. Dependents are not eligible for care at Kenner; they must go through TRICARE for services.

John Randolph Medical Center in Hopewell is equipped to handle urgent physical and behavioral health care situations. John Randolph will work with TRICARE to provide services and coordinate paperwork. John Randolph's main phone number is (804) 541-1600 and TRICARE's number is (877) 874-2273. Kenner Army Health Clinic may refer people to John Randolph for behavioral health services if it is after Kenner clinic's daytime hours or in cases of patient overflow. If behavioral health services are sought at John Randolph, one can expect to go through the emergency room prior to screening.

*******Provider instruction:** Discuss importance of participation in study

Dismiss the Usual Services Group

If you are in the Usual Services Group, you are good to go for today and you may be on your way. Thank you so much for participating in this study and we will see you in a couple of weeks for the first survey. If you are in the Workshop Group, please remain here, we have a few more things to cover.

*******Provider instruction:** Pause while the Usual Services Group participants are excused →

Description of TEAM Program Services

Workshops and Handouts

All right, if you are still here it means that you are in the Workshop Group, is this correct? The format of each of these workshops will be very similar: An overview of PFA will be followed by an in depth look at one or two of the principles of PFA, and how they might be applied to post-deployment life situations. Service members have told us about typical post-deployment challenges and concerns and we will weave some of these themes into the presentations. We will talk about how you can apply the PFA principles to your life and how you can use them to support a buddy or someone else. We'll also talk about the things that get in the way of seeking outside assistance—even when we know we aren't handling a situation well ourselves. We call these barriers to care.

We will also distribute handouts relevant to the topics that were discussed that day. The handouts are for you to read and keep. You will receive more than 20 handouts over the course of this program. We recommend putting them all together in the folder we provide so you will be able to find and refer to them as needed.

Web Site, Email and Telephone Information Services

We want to tell you more about the web site, email and telephone information services available to you. As part of the education and training program, you and your spouse will have access to the TEAM web site, email service and the telephone information line. The TEAM web site has program information including synopses of the education and training curricula; copies of the handouts you receive in the workshops; additional handouts that are not distributed in the workshops; links to resources and our contact information. You can access the web site anytime at www.TeamTrainingOnline.org.

The email service and toll free telephone information line are available for you and your spouse to contact us with any questions or comments you may have about what is learned in the TEAM workshops. The email address is info@TeamTrainingOnline.org. You can send an email to us at any time and we will respond during weekday duty hours. The number to the TEAM toll free telephone information line is 1-866-553-5808. The telephone line is staffed by members of our group during weekday duty hours. The phone line is equipped with an answering machine so you can leave a message at any time and we will return your call.

For ease of accessing these resources, the address to the TEAM web site, the TEAM email address and the number to the TEAM telephone information line are printed at the bottom of all handouts. The email address and number to the telephone line are also listed on the web site.

Spouse Participation and Childcare Services Information

We are now distributing an invitation to the education and training program for spouses.

*******Provider instruction:** Distribute an envelope with the following handouts inside:

- *Letter of Introduction to Spouses*
- *Childcare Information*

For those of you with a spouse, please take the invitation home with you today and give it to your spouse. It describes the spouse program and invites your spouse to participate. The invitation states why it is important for your spouse to participate and lets him/her know that we will be making contact with him/her soon. Please give the invitation to your spouse today.

We have arranged for childcare services to be available on post during the spouse groups. In order to take advantage of the childcare services, you must register your child for "hourly care" with the Child, Youth & School Services Central Registration Office. Their office, located in building 10612, is open Mon. thru Fri., 7:30 a.m. - 1 p.m. and 2 - 4:30 p.m. Call (804) 765 3852 or (DSN) 539 3852 or visit the website, http://www.leemwr.com/cys/cys_cys.html. It is recommended that you register your child for care as soon as possible. Registration requires a current shot record and three local emergency contacts. Information on childcare services is in the envelope with the letter to spouses.

Brief Education and Training for the Workshop Group

We have a few more things to talk about. We are going to talk about Psychological First Aid and the first principle of PFA, Safety. Then we have another handout for you.

Introduction to Psychological First Aid

*******Provider instruction:** Distribute handout: *Five Principles of Psychological First Aid*

We are distributing a handout of the five principles of Psychological First Aid. The five principles are Safety, Calming, Connectedness, Self-efficacy and Hope/Optimism. The principles of PFA can be applied to the social, interpersonal and occupational challenges that you may encounter now that you are home. We refer to these challenges as secondary adversities. The skills you learned to deal with challenges during your deployment may not be useful or apply to the challenges you now face at home. The monthly workshops will help you learn and apply the PFA principles to the challenges you face and help you overcome barriers to seeking healthcare when problems are too big to solve on your own. In each of the upcoming workshops, we will use examples of the real life challenges you face to illustrate how PFA works.

Safety

The first principle of Psychological First Aid (PFA) is Safety—making your environment as safe as possible. Downrange safety meant things like securing the perimeter, setting up security checkpoints, establishing and practicing tactics for engaging the enemy and identifying a battle buddy who would look out for you. At home, safety means watching out for different types of problems such as the consequences of excessive alcohol use, risky behaviors, driving too fast or spending too much money. Responsible use of alcohol can be part of a good time with friends, but a DUI or alcohol related accident could have a great negative impact on your career and have secondary effects on your family. If you go out and party, call a taxi or identify a buddy as your designated driver to watch out for you and keep you safe. The handout, *Resources at Fort Lee* and the *Wallet Card* have phone numbers for taxi services in your area. If you carry the *Wallet Card*, you will always have the number to for taxi in your pocket in case you need it. Also, if either you or your buddy becomes concerned about drinking or its effects, there are phone numbers and web links on the handouts that can provide more information. The point of the first principle of PFA is “safety first.” Besides taking care of yourself, take care of your buddy too!

*******Provider instruction:** Distribute handout: *Returning Home: Advice for Soldiers*

Conclusion/Close

We appreciate you spending your time with us today. We will stay in the front of the room to answer any other questions you may have. Thanks a lot for your attention.

----- End of Orientation -----

WORKSHOP 1

(Approximately 2 month post deployment)

Outline

FIRST HOUR

A. MA TEAM assessment

- The Usual Services Group is excused →
- Break for Workshop Group

SECOND HOUR (Start of Workshop 1 training)

A. Introduction for the Workshop Group

B. Principles of Psychological First Aid

C. Common Reactions to Difficult Events

- Intrusive reactions, avoidance and withdrawal, physical arousal, trauma reminders, change reminders, grief reactions, depression, anxiety, guilt/shame, physical reactions
- Secondary adversities

D. Basic Coping

- Good/bad coping strategies
- Coping Within the Family

THIRD HOUR

A. Other Common Concerns

- Anger Management
- Highly Negative Emotions (Guilt & Shame)
- Sleep Problems
- Alcohol and Substance Use

B. Safety

- Buddy Care—Safety

Introduction

Thank you all for agreeing to participate in this training and research program. Today is the first of our three primary workshops. It has been about a month since you agreed to join us for this training, so we will begin with a brief overview of Psychological First Aid (PFA) and then talk about common reactions to stressful events, basic methods of coping, and some problems that are more specific to returning from a deployment.

This educational program is based on the concept of Psychological First Aid (PFA), a set of recommended principles developed by the National Center for PTSD, the National Child Traumatic Stress Network and others for assisting people after disasters and other traumatic events. We have adapted the PFA principles to make them applicable to Soldiers and their spouses in dealing with adjustments associated with the return from deployment.

Just a reminder, we have available a toll-free telephone information line (1-866-553-5808) or email service (info@TeamTrainingOnline.org) as well as information available at the TEAM web site (www.TeamTrainingOnline.org). Before we begin the training, do you have any questions? Ok, great!

Principles of Psychological First Aid

We know that Mortuary affairs Soldiers encounter many difficult situations. While deployed, you may have experienced, seen or thought about such things as:

- Physical aspects of remains (burned, decomposed, mutilated, dismembered, and others)
- Handling personal effects
- Learning about the life of the deceased
- Contact with members of the unit of the deceased
- Contact with local nationals who have lost family members
- Working with remains of insurgents
- Not being able to talk about your work with family or Soldiers outside of the MA field
- Being avoided by other Soldiers because of your MA duties

You may have also faced:

- Fatigue from long hours and irregular sleep cycles
- Lack of logistical and personal support
- Worry about your personal safety
- Lack of communication with family back home
- Worries about your family back home
- Missing important events like birthdays and holidays
- Money problems
- Lack of enjoyable activities while downrange

The hardships of being deployed and away from family can place considerable strains on Soldiers and families and can compromise the process of moving on with life. We present this education and training program after your deployment because the principles on which it is based, the five principles of PFA, are meant to help one better cope with stressful events and manage our reactions to those events.

The five main principles of PFA are:

1. Physical and psychological safety
2. Calming
3. Connectedness
4. Self-efficacy (psychological and practical ability to manage demands of the environment)
5. Hope/optimism

We will talk about physical and psychological safety later today and cover the other principles in detail in the next two workshops. As we proceed, consider how the PFA skills we will discuss relate to stressful events you are working through or may face in the future.

Common Reactions to Difficult Events

We are going to be using the term “*difficult event*” in our discussions to describe any events that fall into the range of mildly stressful to very traumatic and challenging. For example, difficult events can include natural disasters such as floods, earthquakes or tornadoes or man-made disasters such as industrial accidents or war. Difficult events can also be personal events such as relationship problems, conflicts with other individuals, financial problems or many other types of events you find stressful.

We have all experienced difficult events, some long-term, some short-term and some much more stressful than others. Our reactions to these events can vary considerably. Immediate reactions to very stressful events might include alarm, fright and tension. Longer-term reactions might include feelings of anxiety, grief or hopelessness and troubling memories of the event.

Learning Objectives

- To understand common reactions to stressful events

*******Provider note:** Avoid pathologizing Soldiers’ responses; don’t use terms like “symptoms” or “disorder.” Avoid providing “blanket” reassurance that stress reactions will disappear. Such reassurances may set up unrealistic expectations about the time it takes to recover.

Now we are going to talk about possible reactions to difficult events, including events that could be considered traumatic. First, we are going to talk about three types of posttraumatic stress reactions: 1) intrusive reactions, 2) avoidance and withdrawal reactions, and 3) physical arousal

reactions. Then, we will talk about reminders of traumatic events and other common reactions. We will go on to talk about general strategies for coping with stress and then get into some common problems that may occur after difficult events.

1. Intrusive reactions are ways in which a traumatic experience comes back to mind. These reactions include distressing thoughts or mental images of an event (for example, picturing what one saw), or dreams about what happened. Intrusive reactions also include upsetting emotional or physical reactions to reminders of the experience. Some people may feel and act like one of their worst experiences is happening all over again. This is called a “flashback.” Naturally, we want to avoid things that are harmful and remember what they are so we don’t experience them again, but we don’t want to be recalling and thinking about danger when no danger is present; that would be an intrusive reaction.

2. Avoidance and withdrawal reactions are ways people keep away from, or protect against, intrusive reactions. This includes trying to avoid talking, thinking and having feelings about a traumatic event, and to avoid any reminders of the event, including places and people connected to what happened. The problem with avoidance and withdrawal is that emotions can become restricted, even numb to protect against distress. Feelings of detachment from others may lead to social withdrawal and there may be a loss of interest in usually pleasurable activities.

3. Physical arousal reactions are physical changes that make the body react as if danger is still present. These reactions include constantly being "on the lookout" for danger, being jumpy or easily startled, being irritable or having outbursts of anger, having difficulty falling or staying asleep, and having difficulty concentrating or paying attention.

Trauma Reminders can be sights, sounds, places, smells, specific people, a time of day, situations or even feelings, like being afraid or anxious. Trauma reminders can evoke upsetting thoughts and feelings about what happened during a traumatic event. Examples might include the sound of helicopters, screaming or shouting and specific people who were present at the time. Reminders are related to a specific type of difficult event, such as an earthquake, tornado, fire, assault or act of war. Over time, avoidance of reminders can make it hard for an individual to do normal activities.

Loss Reminders can also be sights, sounds, places, smells, specific people, the time of day, situations or feelings. Examples include seeing a picture of a lost loved one, or seeing their belongings, like their clothes. Loss reminders bring to mind the absence of a loved one. Missing

the deceased can bring up strong feelings, like sadness, feeling nervous, feeling uncertain about what life will be without them, feeling angry, feeling alone or abandoned, or feeling hopeless. Loss reminders can also lead to avoiding things that people want to do or need to do.

Change Reminders can be people, places, things, activities or hardships that remind us of how our lives have changed from what they used to be as the result of a difficult event. This can be something as simple as waking up in a different bed in the morning, going to a different school or being in a different place. Even nice things can remind us of how life has changed, and make us miss what we had before.

Other kinds of reactions to very difficult events include grief reactions, depression, anxiety, guilt/shame and physical reactions.

Grief Reactions are prevalent among those who survive difficult events and have lost someone they care about. Loss may lead to feelings of sadness and anger, guilt or regret over the death, missing or longing for the deceased, and dreams of seeing the person again. Sometimes people stay focused on the circumstances of a death, including being preoccupied with how the death could have been prevented, what the last moments were like and who was at fault. These reactions can interfere with grieving, making it more difficult for the individual to adjust to the death over time.

Depression is associated with prolonged grief reactions and strongly related to exposure to stressful events. Depressive reactions can include persistent depressed or irritable mood, loss of appetite, sleep disturbance, greatly diminished interest or pleasure in life activities, fatigue or loss of energy, feelings of worthlessness or guilt, feelings of hopelessness, and sometimes thoughts about suicide. Demoralization is a common response to unfulfilled expectations about improvement in secondary adversities and resignation to adverse changes in life circumstances.

Anxiety and fear are common reactions after difficult events. Anxiety can present in the form of excessive worry, physical tension, panic and fear. Anxiety reactions can also overlap with other problems including poor concentration, irritability and impaired sleep.

Guilt/Shame Some people have a lot of guilt and shame after difficult events. Such feelings may be very painful, difficult and challenging and people may be ashamed to disclose these feelings. Attributing excessive blame to oneself is not helpful and may add further distress.

Physical Reactions may be experienced after difficult events, even in the absence of an underlying physical injury or medical illness. Common physical reactions include:

- Headaches or dizziness
- Stomach aches, having sharp pain in your stomach
- Pains or tightness in your chest
- Feeling low in energy or slowed down
- Hot flashes or cold tingles (suddenly feeling hot or cold for no reason)
- Difficulty swallowing, feeling a strange lump in your throat
- Feeling weak in parts of your body
- Nausea or upset stomach (throwing up or feeling like you might, having butterflies in your stomach)
- Bowel or bladder problems (constipation, diarrhea, excess gas, bedwetting)
- Your heart beating too fast (even when you're not exercising)
- Trouble catching your breath (when you're not exercising)
- Pains in your body that don't have a known medical cause (sore joints or muscles)
- Numbness or tingling in parts of your body
- Feeling like your arms or legs are very heavy and hard to move
- A sense that it is hard to get going in the morning

Physical reactions may be due to the stress and strains of experiencing difficult events and can be another indicator of the amount of stress a person is experiencing.

Such reactions are understandable and not unusual. However, some individuals may view their reactions in negative ways (for example, my reactions means, "There's something wrong with me" or "I'm weak"). After difficult events, stress reactions may continue for a while, but generally diminish. If these reactions continue to interfere with a person's ability to function adequately for over a month, psychological services should be considered. Be aware that many people also see positive reactions, including appreciating life, family and friends, or strengthening of spiritual beliefs and social connections.

Secondary adversities are other events that happen after the primary difficult event. Examples of secondary adversities include financial problems, legal problems, unexpected loss or change in living conditions, or health problems. Secondary adversities can prolong stress and grief reactions, raise spiritual questions (like, "Why is this happening to me?"), and increase the risk for depression, demoralization, and hopelessness. Secondary adversities can greatly interfere

with functioning at work, in the family, in romantic and interpersonal relationships, and in the community.

Basic Coping

In general, difficult events may overwhelm an individual's ability to cope, putting him/her at risk for losing a sense of competence to handle problems. Feeling that one can cope is important for working through and transcending the difficult event. Often, just hearing about some basic coping mechanisms that have been helpful to others can jump-start one's motivation, creativity and natural resilience.

There are a variety of ways to cope with difficult events, reactions to those events and secondary adversities. We will mention some good and bad coping actions.

*******Provider instruction:** Distribute handout: *Common Reactions when Dealing with Difficult Events*

Learning Objectives

- To understand basic coping options/skills and make goal-oriented choices about coping
- To identify and acknowledge your personal coping strengths
- To think through the negative consequences of bad coping actions
- To enhance your sense of personal control over coping
- To know how to help your buddy, family, or others with coping options/skills

Good coping actions are those actions that help to reduce anxiety, lessen distressing reactions, improve the situation or help people get through bad times. In general, coping methods that are likely to be helpful include:

- Talking to another person for support (we will talk more about getting and giving support next month)
- Getting needed information
- Getting adequate rest, nutrition, exercise
- Engaging in positive distracting activities (sports, hobbies, reading)
- Maintaining a normal schedule to the extent possible
- Telling yourself that it is natural to be upset for some period of time
- Scheduling pleasant activities
- Eating healthy meals

- Taking breaks
- Spending time with others
- Participating in a support group
- Using calming self talk
- Using relaxation techniques
- Exercising in moderation
- Seeking counseling
- Keeping a journal
- Focusing on something practical that you can do right now to manage the situation better
- Using coping methods that have been successful in the past

Bad coping actions are those actions that tend to be ineffective in addressing problems or cause more problems than they solve. Such actions include:

- Using alcohol or drugs to cope
- Withdrawing from activities
- Withdrawing from family or friends
- Working too many hours
- Getting violently angry
- Excessive blaming of self or others
- Overeating or under-eating
- Spending too much time watching TV or movies, surfing the web, or playing video games
- Doing risky or dangerous things
- Not taking care of oneself (sleep, diet, exercise, etc.)

Now let's talk about some specific problem areas and ways to cope with them.

Coping Within the Family

Establishing family routines after a deployment is important for family recovery. It is especially important to restore and maintain family routines such as meal times, bedtime, wake time, reading time, play time, and to set aside time for the family to enjoy other activities together.

During deployment, your family members may have had to adapt to new challenges and hardships. They may have developed new daily routines and ways of coping. Returning home to different routines and means of handling problems can be difficult to deal with and can lead to

family members not feeling appreciated or understood, not supporting each other, or getting into arguments. It is helpful for family members to develop a mutual understanding of their different experiences during the time of deployment and to develop a family plan for talking about these differences. Be understanding, patient and tolerant of differences in ways your family has learned to cope with challenges during your deployment. Talk about things that are bothering each family member, so you will know when and how to support them. Family members can help each other in a number of ways like listening, comforting with a hug, doing something thoughtful like writing a note, or getting a family member's mind off troubling thoughts by playing a game, etc.

Family Milestones, Goals and Being Deployed

While downrange, you may have missed important milestones such as:

- Birthdays
- Graduations
- The birth of a child
- A child learning to walk
- Having a child leave home
- The death of a loved one
- Other important events

Were there any special events that you missed? Were there any goals that you were working towards that were interrupted by deployment, such as buying a new house or getting married?

Sometimes we measure our progress in life by these milestones and missing them can feel like a great loss. It can help to find alternative ways to handle the missed event or interruption in goals. You might consider:

- Honoring the event now that you are home (e.g., having a birthday party, celebrating anniversaries, visiting the gravesite of a relative who has died)
- Postpone the event to a later date (e.g., buying a house or getting married at a later date)
- Change your expectations, decide that you can tolerate the loss or postponement
- Not being too hard on yourself. You might change negative thoughts about missing the event to thoughts like: "I didn't want to miss the event and I would have been there if I had been able, but I was called away to do important work for my nation." Such thoughts may lessen your feelings of guilt.

Other Common Concerns

Anger Management

After difficult events, feelings of anger and frustration and irritability are common. Some anger is normal and may even be helpful. However, too much anger can increase interpersonal conflict, push others away or potentially lead to violence

Some questions you might consider are:

- How is anger affecting your life?
- How is anger affecting your relationship with family members and friends, or your ability to parent?
- How might holding on to anger help or hurt you versus coping with it, letting it go, or directing it toward positive activities?
- What changes would you like to make to address your anger?

Some anger management skills that you can apply:

- Take a “time out” or “cool down” (walk away, calm down and do something else for a while).
- If you are a parent, have another family member or other adult temporarily supervise your child while you are feeling particularly angry or irritable.
- Blow off steam through physical exercise (go for a walk, jog, do pushups).
- Distract yourself with positive activities like reading a book, praying or meditating, listening to upbeat music, going to religious services or other uplifting group activities, helping a buddy or someone else in need.
- Remind yourself that being angry will not help you achieve what you want, and may harm important relationships.
- Talk to a buddy about what is angering you.
- Keep a journal in which you describe how you feel and what you can do to change the situation.
- Look at your situation in a different way, try to see your problems from another’s viewpoint, or find reasons that your anger may be excessive.

Highly Negative Emotions (Guilt and Shame)

Let's talk a little bit more about guilt and shame. Some people feel guilty after a difficult event

either because of things that they did or did not do during the event or because they feel that they may have caused or contributed to the event. Some events are out of our control; they are beyond our ability to prevent or stop them from happening. Even if you believe you were at fault that does not make it true. Dwelling on actions taken or not taken during the event is not productive. If there is something to be learned from the event, (e.g., “If that ever happens again I am going to do X or not do X”) then accept what you have learned, forgive yourself, and let go of the guilt. You can’t go back and change the past.

You might also consider:

- How you could look at the situation differently? What is another way of thinking about it?
- How might you respond if a good friend was talking to himself/herself like this? What would you say to him/her? Can you say the same things to yourself?

Sleep Problems

Sleep difficulties are common following difficult events such as return from deployment. Some people tend to stay on alert at night, making it hard to fall asleep and causing frequent awakenings during the night. Worries about adversities and life changes can also make it hard to fall asleep. Disturbance in sleep can have a major effect on mood, concentration, decision-making and risk for an accident and injury. Have your sleep routines and sleep-related habits changed? Are you having any trouble sleeping?

Good habits for sleep include:

- Spend time working through bothersome problems during the day so that you don't feel the need to work on them at night
- Talk to buddies or others about immediate concerns. Get support!
- Increase regular exercise, although not too close to bedtime
- Limit daytime naps to 15 minutes and don't nap later than 4 p.m.
- Eliminate consumption of caffeinated beverages in the afternoon and evening
- Reduce alcohol consumption --- alcohol disrupts sleep
- Relax before bedtime by doing something calming, like listening to soothing music, meditating, or praying
- Go to sleep at the same time and get up at the same time each day

Alcohol and Substance Use

*******Provider instruction:** Distribute handout: *Alcohol, Medication and Drug Use After Difficult Events*

Exposure to difficult events, ongoing stress and other adversities can lead to increased alcohol or drug use, relapse of past substance abuse, or a new onset of substance abuse. This can be dangerous and lead to self-destructive behavior (e.g., drunk driving), and can set up a pattern of abusing substances that can have long-term negative consequences. If you are having trouble with alcohol or drugs, seek help.

If you use alcohol or other substances, some things you might want to consider include:

- Are you self-medicating with alcohol or other substances to reduce bad feelings?
- What do you see as the positives and negatives of using substances to cope?
- What difficulties would you have in changing your substance use behavior?
- Do you feel confident that you can make and keep a commitment to yourself to either use alcohol or other substances safely or not at all?

Break #1

Safety

Learning Objectives

- To understand important aspects of feeling and being safe

Safety is one of the components of PFA. Safety is not a new idea for you, it was emphasized in the Battlemind training that you received. In Battlemind you were cautioned to beware of driving in an unsafe manner, weapons safety for those who have weapons at home, and the need to watch out for the angry feelings that you may have had downrange, but that are not appropriate back here.

We are going to talk about safety in ways that are more general --- how safety can affect many areas of your life today. Then we will talk about some practical things you can do to (1) make a judgment about your safety and the safety of others, and (2) how you might deal with safety issues when you recognize them in yourself or in someone else.

Let's start by hearing what you think about safety:

- What is the feeling of safety? [ask for response]
- How does it affect our daily lives? [ask for response]
- What can we do or not do to improve our safety? [ask for response]

When we perceive a situation as being a threat to our health or well-being, our bodies naturally react with a stress response that has been called the Fight or Flight Response. This response involves the release of stress hormones, which produce changes in our bodies that prepare it to fight off an enemy or flee from danger.

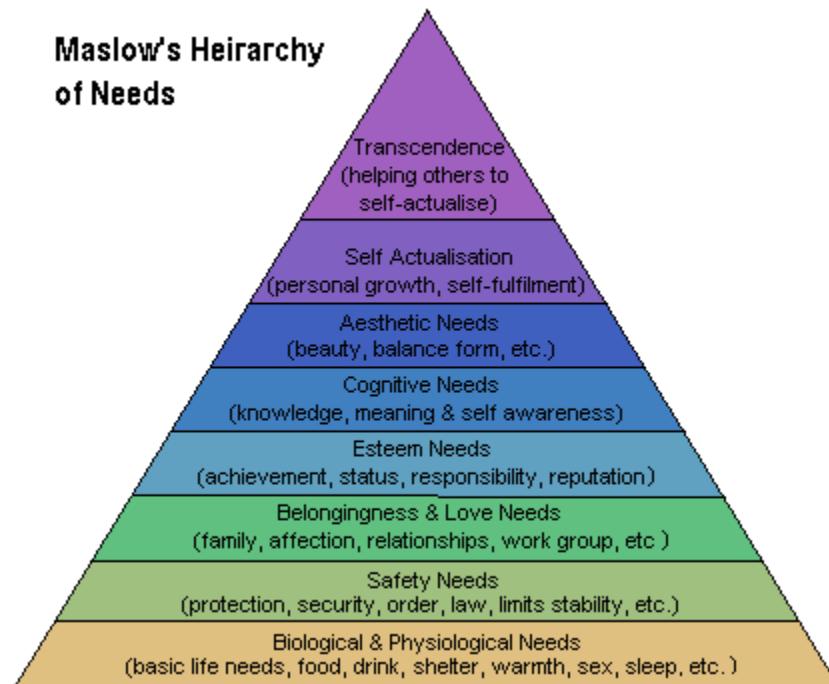
When the fight or flight response is activated you might feel more alert, on the lookout for danger, prepared for action, with muscles tensed and heart and breathing accelerated. All these responses may be very good if you have to jump out of the way of a moving vehicle or fight off an attacker. However, they are not so helpful and can be counter-productive if there is minimal or no actual threat to your health or well-being. Long-term activation of the fight or flight response can contribute to a host of health problems, such as high blood pressure.

Usually people walk around with some belief in their sense of safety, some sense that their world will not come crashing down on them. This has been called the “bubble of safety” or “shield of confidence.” However, very difficult events, such as a threat to life or limb, can alter our sense of safety - burst our bubble of safety or lower our shield of confidence. In these situations, it may take some time before a sense of safety can be restored.

Being safe and feeling safe is not the same thing. Without both of these, we may not be able to perform at our best. For example, one could stand on the curb of a street and think they are safe, and yet, they might be hit by a vehicle that is driving too close to the curb. On the other hand, one could stand on the side of the curb and think they are in danger of being hit, when in fact they are not. The perceptions of being in a threatening situation - that is our thoughts and beliefs of safety - sometimes match reality and sometimes they do not.

Feeling safe is important. The psychologist Abraham Maslow proposed that everyone is motivated by a common hierarchy of needs. These needs range from lower level basic needs such as food, drink, shelter and sleep to higher-level needs such as knowledge, personal growth and self-fulfillment. The important idea behind this model is that one cannot attain the higher level needs without first attaining the ones below it. For example, one must have food, drink,

shelter, and sleep before we can work on higher-level needs such as personal growth and achievement. We see in the pyramid that safety is next to the bottom, just above the basic life needs. We must have a sense of being safe before we can work on our higher-level aspirations.



Increasing Your Sense of Safety

Downrange the threats you faced may have been of great risk to the things you value, like your life. Reactions of fear, worry, anxiety and the physical responses that accompany such threats are not unusual. There is good reason for our reactions to threat --- our reactions may keep us alive. If the threat of danger is ongoing, these reactions will continue to persist. However, now that you are back in the States, the threats you face may be different, fewer, or at least less likely to be lethal. It may take some time for your body to adjust to responses that are appropriate to the challenges that you now face.

We have already talked about the use of alcohol and other substances as a bad way of coping with stress. Substance use also puts your safety at risk through reduction of defenses and good sense, reduction of reaction time, increasing your risk for falls or injury, reckless driving, and many health and relationship problems.

There may be specific triggers, reminders of difficult events that cause you to feel unsafe. These

might include reminders of things experienced during deployment. For example, noises, crowds, bridges, and reminders of remains including odors.

There are ways to increase your sense of safety. The first is to be connected with [know] your feelings/emotions and your specific triggers, and use threat reappraisal. Threat reappraisal is reevaluating your actual risk of harm and responding appropriately. If you recognize that you are not feeling safe, ask yourself, “Am I really in danger?” This will help you decide what action to take to improve your sense of safety. In some cases it may be enough just to recognize that you are not really in danger.

Another strategy to improve safety is to remove whatever is preventing you from feeling safe from your environment or remove yourself from the environment where you feel unsafe. This strategy must be done within reason. It is not in your best interest to avoid all places and situations where you feel threatened, but are actually safe. For example, because of your experiences while deployed, you may feel unsafe in crowds or on bridges. Back in the States, crowds and bridges do not carry the same risks for harm. Avoiding crowds and bridges altogether will not help you regain your sense of safety.

Increasing social contact and support also helps. This may include talking with others about when and why you feel unsafe and getting their feedback. Calming techniques will also help you relax and feel more comfortable. We will be talking more in detail about increasing social support and calming techniques in our next workshop.

Buddy Care - Helping Your Buddy be Safe

Promoting safety can reduce distress and worry for your buddies. Safety can be supported in a number of ways, including helping your buddy:

- Get current accurate and up-to-date information
- Get connected with available practical resources
- Get connected with others who have shared similar experiences
- Do things that are active, practical, and familiar
- Avoid exposure to information that is inaccurate or excessively upsetting. This may include helping or reminding your buddy to limit exposure to TV, movies, radio, sights, sounds, or smells that can be upsetting. It might also mean not talking about traumatic events or reminders of the difficult event.

You can also help your buddy reevaluate perceptions of threat by discussing the situation. This may involve

- Challenging the perception of threat, such as “this situation is not the same as the one that you faced in the past.”
- Emphasizing the positive ways in which your buddy faced and overcame a previous threat.
- Acknowledge your buddy’s reaction and express your understanding and interest in helping. This will go a long way in making your buddy feel accepted and cared for.

You may also help your buddy, family members or others with calming. This will be discussed in the next workshop.

We recommend that whatever you hear in this discussion remain in this group. Please do not discuss others’ concerns outside of this group.

Conclusion/Close

----- End of Workshop 1 -----

WORKSHOP 2

(Approximately 3 months post deployment)

Outline

FIRST HOUR

A. MA TEAM assessment

- The Usual Services Group is excused →
- Break for Workshop Group

SECOND HOUR (Start of Workshop 2 training)

A. Calming

- Breathing
- Muscle Relaxation
- Other Relaxation Techniques
- Buddy Care—Calming

THIRD HOUR

A. Connectedness

- Different Types of Support
- Five Steps to Getting Support
- Buddy Care—Support

B. Barriers to Care

Introduction

Welcome back to our second workshop on Psychological First Aid. Thanks for completing the surveys. Before we get into today's training, we want to remind you that we have a toll-free telephone information line (1-866-553-5808), a website (www.TeamTrainingOnline.org), and email service (info@TeamTrainingOnline.org).

Just to remind you, this educational program is based on the concept of Psychological First Aid (PFA), a set of recommended principles developed by the National Center for PTSD, the National Child Traumatic Stress Network and others for assisting people after disasters and other traumatic events. We have adapted the PFA principles to make them applicable to Soldiers and their spouses in dealing with adjustments associated with the return from deployment. OK, let's begin:

Calming

*******Provider instruction:** Distribute handout: *Calming Techniques*

It's very common for people who have experienced a difficult event to feel tense, anxious, overwhelmed with emotions and unable to stop thinking about or imagining what happened. These are normal and expected responses to difficult events.

In the presence of danger, the body becomes alert, aroused and ready to deal with the threat. In a sense, the body becomes anxious. In the absence of real danger, the anxiety is unnecessary, and may have negative consequences for one's health. For example, it can cause headaches, appetite disturbance, problems with pain, sleep disturbance, and high blood pressure. The arousal and anxiety can also predispose one to social problems like violence and alcohol abuse. Extremely high arousal, numbing, or extreme anxiety can interfere with sleep, eating, decision-making, parenting, work, and other life tasks. Calming is a skill that can be used whenever heightened arousal, tension, and anxiety occurs and is especially important when reactions are so intense and persistent that they interfere with the ability to function.

We are going to teach you some specific skills that can help you minimize the negative effects of arousal, tension and anxiety. Think of these skills as you would any other skill (like riding a bike). They will take time to master, but once you learn them, they become quite easy to apply. It will take time to learn to use them effectively and it is important to practice these skills on a regular basis, particularly right after you learn them.

Learning Objectives

- To learn techniques to calm yourself when highly aroused, tense, anxious or emotionally overwhelmed
- To learn how to help your buddy become calm

Before we start talking about the calming techniques, I am wondering, have you ever learned any relaxation techniques before?

If yes, what have you learned and has it helped? (*Engage in brief discussion.*) OK, I am still going to teach you this skill.

If no, okay, then this will be something new for you. I hope that you will find these new techniques useful.

We are going to teach you a breathing technique, a muscle relaxation technique, and a cognitive

technique. We will start with the breathing technique.

Breathing Technique

First, let's talk about why breathing can help and how to retrain your breathing to a style that can reduce physical tension and anxious feelings. When we get aroused, tense and anxious, our body responds by changing the way we breathe. We tend to breathe faster and shallower. This is an important point because breathing helps us regulate different gases in our body that are necessary for healthy functioning. There is always a balance between the level of oxygen and carbon dioxide in our body. When we get aroused and anxious, our breathing changes in such a way that the balance is upset. When the balance is upset, it causes us to feel even more of the physical reactions of arousal and anxiety. Thus, the way we breathe when we get upset can be extremely important in managing our arousal, tension, and anxiety and preventing it from getting worse. We are going to teach you how to retrain your breathing so you can begin using the breathing technique right away.

Most of us realize that our breathing affects the way we feel. For example, many people believe that taking a deep breath helps them calm down when they are stressed or anxious. However, contrary to this popular belief, taking a deep breath usually is not helpful and can actually lead to even more feelings of anxiety. A good way to cope with anxiety is to take a normal breath and exhale slowly. While you exhale, try saying the word CALM or RELAX very slowly to yourself, like this, C-a-a-a-a-a-l-m. If you don't find the words "calm" or "relax" to be helpful, it is also fine to use the word "exhale" or some other word of your choosing.

In addition to exhaling slowly while saying "calm" to yourself, I want you to slow down your breathing. Very often, when people become frightened or upset, they feel like they need more air and may hyperventilate in response to that feeling. Hyperventilation, which simply refers to breathing in excess oxygen, does not have a calming effect. Hyperventilating tells our bodies to prepare for danger and causes feelings of anxiety. Unfortunately, when we are under stress, many of us hyperventilate without even realizing it. Unless we are preparing for a very dangerous situation, we often don't need as much air as we are taking in. If we want to calm down, what we really need to do is to slow down our breathing and take in less air.

*******Provider note:** Model how to inhale: exhale slowly, say "CALM," pause, count to four, and repeat. Then ask the Soldier to perform the exercise according to the following instructions.

Let's practice: Focus on your breathing. Take a normal breath and exhale very slowly while silently repeating the cue word. Pause and count to four before taking the next breath. Repeat the entire sequence 10 to 15 times. How did that go for you? Did you have any problems?

There is a slight variation to this technique where you say calming phrases rather than just saying one word. Try this: inhale slowly through your nose (one-thousand one; one-thousand two; one-thousand three), and comfortably fill your lungs all the way down to your belly. Silently and gently, say to yourself, "My body is filling with calmness." Exhale slowly through your mouth (one-thousand one; one-thousand two; one-thousand three), and comfortably empty your lungs all the way down to your abdomen. As you exhale, silently and gently say to yourself, "My body is releasing tension." Repeat the entire sequence 10 to 15 times.

The breathing technique will be helpful for you whenever you feel:

- Tense, irritable, anxious, frustrated or annoyed
- Shaky, trembling or feeling "keyed up"
- Out of control or have the urge to escape your current situation
- Find it hard to relax
- Not sleeping or have poor sleep
- Have difficulty concentrating

In addition, it will help in specific times and situations like:

- In times of high stress (e.g., traffic)
- When encountering reminders of difficult events
- When emotionally upset (e.g., after arguments with a spouse or family member)

If you practice the breathing technique on a regular basis, regardless of whether you feel tense or anxious, you will be better able to use this skill when you really need it. Once you have some experience with the breathing technique, you can practice and use it just about anywhere (e.g., while driving, in a meeting).

Muscle Relaxation Technique

In addition to changing our breathing patterns, we often react to stress by "tensing up" our muscles. When this response is maintained, waste products build up in the muscle, causing muscle pain. This can lead to headaches, increase in back pain, and other physical complaints.

We can counteract the negative effects of tension by learning to identify when our muscles are tense and subsequently letting them relax. The following exercise will help you to recognize when you are holding tension in your muscles and help you to get rid of that tension. This technique was adapted from Davis, Eshelman, and McKay's 1995 *Relaxation and Stress Reduction Workbook, Fourth Edition*. This book is a great resource for stress reduction techniques and newer editions are available.

Okay, let's try this technique. Get in a comfortable position and relax. Now clench your right fist, tighter and tighter, studying the tension as you do so. Keep it clenched and notice the tension in your first, hand, and forearm. Now relax. Feel the looseness in your right hand, and notice the contrast with the tension. Repeat this procedure with your right fist again, always noticing as you relax that this is the opposite of tension- relax and feel the difference. Repeat the entire procedure with your left fist, then both fists at once. Now bend your elbows and tense your biceps. Tense them as hard as you can and observe the feeling of tautness. Relax and straighten out your arms. Let the relaxation develop and feel that difference. Repeat this and all succeeding procedures at least once.

Turning attention to your head, wrinkle your forehead as tight as you can. Now relax and smooth it out. Let yourself imagine your entire forehead and scalp becoming smooth and at rest. Now frown and notice the strain spreading throughout your forehead. Let go. Allow your brow to become smooth again. Close your eyes now, squint them tighter. Look for the tension. Relax your eyes. Let them remain closed gently and comfortably. Now clench your jaw, bite hard, notice the tension throughout your jaw. Relax your jaw. When the jaw is relaxed, your lips will be slightly parted. Let yourself really appreciate the contrast between tension and relaxation. Now press your tongue against the roof of your mouth. Feel the ache in the back of your mouth. Relax. Press your lips now; purse them into an "O". Relax your lips. Notice that your forehead, scalp, eyes, jaw, tongue and lips are all relaxed.

Press your head back as far as it can comfortably go and observe the tension in your neck. Roll it to the right and feel the changing locus of stress, roll it to the left. Straighten your head and bring it forward, press your chin against your chest. Feel the tension in your throat, the back of your neck. Relax, allowing your head to return to a comfortable position. Let the relaxation deepen. Now shrug your shoulders. Keep the tension as you hunch your head down between your shoulders. Relax your shoulders. Drop them back and feel the relaxation spreading through your neck, throat and shoulders, pure relaxation, deeper and deeper.

Give your entire body a chance to relax. Feel the comfort and the heaviness. Now breathe in and fill your lungs completely. Hold your breath. Notice the tension. Now exhale, let your chest become loose, let the air hiss out. Continue relaxing, letting your breath come freely and gently. Repeat this several times, noticing the tension draining from your body as you exhale. Next, tighten your stomach and hold. Not the tension, then relax. Now place your hand on your stomach. Breathe deeply into your stomach, pushing your hand up. Hold, and relax. Feel the contrast of relaxation as the air rushes out. Now arch your back, without straining. Keep the rest of your body as relaxed as possible. Focus on the tension in your lower back. Now relax, deeper and deeper. Tighten your buttocks and thighs. Flex your thighs by pressing down your heels as hard as you can. Relax and feel the difference. Now curl your toes downward, making your calves tense. Study the tension. Relax. Now bend your toes toward your face, creating tension in your shins. Relax again.

Feel the heaviness throughout your lower body as the relaxation deepens. Relax your feet, ankles, calves, shins, knees, thighs, and buttocks. Now let the relaxation spread to your stomach, lower back, and chest. Let go more and more. Experience the relaxation deepening in your shoulders, arms, and hands. Deeper and deeper. Notice the feeling of looseness and relaxation in your neck, jaws, and all your facial muscles.

Like the breathing technique, the more you practice the muscle relaxation technique the better you will get. For these techniques to be really useful, you should practice at least one of them on a daily basis.

Other Calming Techniques and Tips

Cognitive Techniques: The things we think and the images that we visualize in our heads contribute to our level of relaxation. If we think about troubling events or have troubling images in mind, we can become tense and upset. Similarly, if we think peaceful, pleasant thoughts and visualize pleasant images, it will help us to become calm. You can use this to your advantage by using positive images and thinking positive thoughts. For example, you can imagine being in a very comfortable, safe, and pleasant place. Each person has his or her own idea of what a comfortable, safe, and pleasant place might be. For some, imagining being at a beach, a forest, or at home in a recliner might be best. For others, a comfortable, safe, and pleasant place might be in the company of friends or family. Whatever place you prefer, when you use your imagination to picture yourself in that situation your body will begin to react as if it were there. The more senses you involve, the more realistic it will seem and the more your body will respond to the

imagined environment. For example, you might imagine being in a hammock in your backyard, and seeing the blue sky, feeling the comfortable air and warm sunshine on your skin, and smelling the scent of flowers or pine trees. You can use thoughts or short phrases to augment the imagery. For example, saying:

- I am calm, alert and at peace
- My body is relaxed and calm
- I am relaxed, refreshed and alive
- My arms and legs are warm, heavy and comfortable

You can imagine a place where you have been or make-up a place from scratch. Either way, by using your imagination you are the master and you can include the images and thoughts that you find calming.

There are many tools/techniques to help you calm. Some other helpful calming techniques include meditations, peaceful music, yoga, and exercise. Other considerations include:

- Eliminate behaviors that produce negative emotions (e.g., limit exposure to troubling events and reminders of troubling events such as upsetting TV or movies)
- Increase activities that promote positive emotions including joy, humor, personal interest, contentment, and love
- If you have troubling thoughts and feeling due to a specific difficult event, remind yourself that the thoughts and feelings you have are not dangerous in the way the event may have been

Things that are not helpful for calming include:

- Criticizing yourself for the way you reacted to difficult events
- Overindulging in caffeine and foods with high sugar content
- Self-medication with alcohol or drugs
 - Alcohol and drugs disrupt normal sleep patterns resulting in poor sleep
 - They are an avoidance of stressors rather than a working through of stressors
 - Alcohol and drug use can lead to other serious health problems

Buddy Care - Helping Your Buddy with Calming

Learning Objectives

- To learn how to help a buddy, family member become calm

When a buddy is tense, anxious or emotionally overwhelmed you might notice that they are:

- Angry, irritable or bad tempered
- Less responsive to verbal questions or commands
- Engaging in aimless disorganized behavior
- Easily startled or jumpy
- Experiencing physical reactions such as shaking or trembling
- Looking distracted, worried or in extreme cases glassy eyed or vacant
- Having difficulty concentrating or processing information
- Exhibiting strong emotional responses, crying, or hyperventilating
- Engaging in risky activities
 - Driving aggressively
 - Smoking or drinking more than usual
 - Spending a lot of money

In general, the following steps will help to calm most distressed individuals:

- When you notice a buddy having a problem, respect his/her privacy, and give him/her a few minutes before you intervene. Say you will be available if they need you or that you will check back with them in a few minutes to see how they are doing and ask if there is anything you can do to help at that time.
- Remain calm, quiet, and present, rather than trying to talk directly to the person, as this may contribute to cognitive/emotional overload. Remain available, while giving him/her a few minutes to calm down.
- Stand by and be available should the person need or wish to receive further help.
- Offer support and help him/her focus on specific manageable feelings, thoughts, and goals.
- Give information that orients him/her to the surroundings, such as what will be happening, and what actions he/she may consider.

Use these points to help buddies understand their reactions:

- Shocking experiences may trigger strong and upsetting, self-protective “alarm” reactions in the body --- these are normal reactions
- Intense emotions may come and go like waves
- Sometimes the best way to recover is to take a few moments for calming routines (for example, go for a walk or practice breathing or muscle relaxation techniques)
- Remind them of the value of connectedness --- friends and family are very important sources of support to help one calm down

If your buddy is too upset, agitated, withdrawn or disoriented to talk, is experiencing ongoing intense crying, or shows extreme anxiety, fear, or panic, consider the following:

- Take your buddy to a quiet place to talk
- Ask your buddy to listen to you and look at you
- Find out if he/she knows where he/she is and what is happening
- Ask him/her to describe the surroundings, and say where both of you are
- Enlist other buddies, family or friends in providing comfort to the distressed individual
- Understand what your buddy is experiencing. Is he/she crying, panicking, experiencing a “flashback,” or imagining that a difficult event is taking place again? Address the person’s primary immediate concern or difficulty, rather than simply trying to convince the person to “calm down” or to “feel safe” (neither of which tends to be effective)

If none of these actions seems to help in stabilizing an agitated buddy, a technique called “grounding” may be helpful. You can introduce grounding by saying:

“When feeling emotionally overwhelmed, unable to stop thinking about a difficult event or disoriented, you can use a method called ‘grounding.’ Grounding works by turning your attention from your thoughts back to the outside world. Here’s what you do....”

- Sit in a comfortable position with your legs and arms uncrossed.
- Breathe in and out slowly.
- Look around you and name five non-distressing objects that you can see. For example you could say, “I see the floor, I see a shoe, I see a table, I see a chair, I see a person.”
- Breathe in and out slowly.
- Next, name five non-distressing sounds you can hear. For example you could say, “I hear a woman talking, I hear myself breathing, I hear a door close, I hear someone typing, I hear a cell phone ringing.”
- Breathe in and out slowly.
- Next, name five non-distressing things you can feel. For example, you could say, “I can feel this wooden armrest with my hands, I can feel my toes inside my shoes, I can feel my back pressing against my chair, I can feel the blanket in my hands, I can feel my lips pressed together.”
- Breathe in and out slowly.

If none of these approaches aids in calming, get help from a doctor or mental health professional.

Break #1

Connectedness

Connectedness with others includes *seeking support* and *giving supports to others*. Social support is one of the most consistently identified protective factors for combating stress. After difficult events, a lack of connection with social support may lead to loneliness and emotional distance, which can increase the risk for problems such as PTSD.

Learning Objectives

- To learn basic skills to establish, improve or sustain contacts with primary support persons and community helping resources

*******Provider instruction:** Distribute handouts:

- *Connecting with Others: Giving Social Support*

Social support allows people to:

- Increase opportunities for knowledge and problem solving
- Share experiences and concerns
- Feel needed and wanted
- Feel understood and cared for
- Feel like one fits in and belongs
- Feel reassured that friends and family will be there for you if needed
- Build up confidence that you can handle the problems you are facing
- Get good advice when confronted with a difficult situation

There are times when seeking the help of others is vital. For example:

- An acute medical problem that needs immediate attention
- An acute mental health problem (e.g., someone threatening harm to self or others)
- Domestic, child, or elder abuse
- Significant developmental concerns about children or adolescents
- When pastoral counseling is desired
- Alcohol or drug problems
- Ongoing problems with difficult events (e.g., still having problems 4+ weeks after event)

Different Types of Support

There is a variety of different kinds of support including:

- **Emotional Support:** hugs, a listening ear, understanding, love, acceptance
- **Social Connection:** feeling like you fit in and have things in common with other people, having people to do things with
- **Feeling Needed:** feeling that you are important to others, that you are valued, useful and productive, and that people appreciate you
- **Reassurance of Self-Worth:** having people help you have confidence in yourself and your abilities, that you can handle the challenges you face
- **Reliable Support:** having people reassure you that they will be there for you in case you need them, that you have people you can rely on to help you
- **Advice and Information:** having people show you how to do something or give you information or good advice, having people help you understand that your way of reacting to what has happened is normal, having good examples to learn from about how to cope in positive ways with what is happening
- **Physical Assistance:** having people help you do things, like carrying things, fixing up your house or room, and helping you do paperwork
- **Material Assistance:** having people give you things, like food, clothing, shelter, medicine, building materials or money

Some problems require specific kinds of support. For example, one type of support, like financial advice, can be very helpful in dealing with financial problems, but not helpful in dealing with other problems (like relationship problems). It is best when there is a good match between what the problem demands from the person and what the support provides.

Establishing a Support Network

There are many sources of support including those with whom you have a primary relationship (e.g., spouse/significant other, children, parents, other family members, close friends, neighbors, and clergy) and those outside the primary relationship such as co-workers and hobby or club members (e.g., VFW, Rotary, or book club). Spiritual beliefs and religious practices can be a way to attain support from your higher power, clergy and fellow church members.

Buddy support provides a framework within which Soldiers can give and receive help and assistance from each other. Buddy support allows Soldiers to share experiences, identify daily

personal and interpersonal challenges, gain supportive assistance and become empowered. In providing support to a buddy and engaging the assistance of a buddy, some Soldiers may benefit from strengthening their social skills. Here are some tips for expanding friendships your network of buddy support.

1. Recognize that you are not the only who is nervous about establishing new friends or buddies. Others may be even more nervous about approaching you. Go to places and participate in programs, activities, and groups where you can meet people. Listen to the interest of others. You may have a similar interest that may strengthen a bond of friendship. Be sensitive and respect the privacy of others.
2. Look friendly and approachable. Smile, make eye contact, listen to others and meet them where they are relative to their interest in developing friends or buddy contacts.
3. Learn how to initiate conversation (assignments, commanders, cars, sports, hobbies, etc). Be a good conversationalist. Listen to what others have to say about themselves. Avoid monopolizing the conversation. Be an attentive listener.
4. Accept people as they are. Try not to find fault. Look at the positive aspects of an individual or situation. Be sincere in everything you do. No one likes to be with someone who is not genuine.
5. Be generous with praise and slow with criticism. No one wants to be criticized by someone they hardly know.
6. Be helpful. If you understand something better than someone in a class or on a project, volunteer to help him/her. Volunteer to tutor others.
7. Try to be available if someone needs to talk or asks your opinion about a particular situation. Be careful about offering advice unless you are specifically asked for it. Sometimes a sympathetic ear is all that is desired.
8. Keep communication channels open. Do not expect friendship and buddy networks to happen without some effort. It is a two-way street; call up people and keep in touch with them. If appropriate, follow-up with people you have just met.

9. Learn how to be a buddy to others. Show people that you are reliable and can be trusted. It will encourage others to be your buddy. Sometimes, it is essential to take the first step in developing lasting friendship and buddy networks.

Five Steps to Getting Support

When you know that you need support (or think that it is probably a good idea), it is time to take action. But what do you do? Five steps will help you think through the types of support that would be helpful and figure out how to ask for the kind of support you need:

1. **"What Do I Want?"** The first step is to figure out what you really want or need. For example, sometimes we want to be understood, and sometimes you want advice. There are two parts to this:
 - A. **Look Outside Yourself:** What kind of problem am I facing that I may need support from others to cope with? For example:
 - Do I have to make an important decision (and therefore I need some good advice?)
 - Do I need someone to help me do something?
 - Do I need someone to give me something?
 - B. **Look Inside Yourself:** What am I thinking and feeling inside that I may need support from others to cope with?
 - Do I want someone to just listen and try to understand what I'm going through?
 - Do I want a hug from someone?
 - Do I want companionship?
 - Do I want encouragement that I can handle a difficult situation?
 - Do I want reassurance that people will be there for me?
 - Do I want someone to help me get my mind off my problems?
2. **"Whom Should I Ask?"** The second step is to think about who has been or could be a good source of support for what you want? You need to ask yourself:
 - Who has been a good source of this type of support in the past?
 - Do I have others that I can depend on to provide this type of support? For example, even if you have never gone to him/her to talk before, do you

- have an aunt or uncle whom you think would be a good listener?
 - Do I need to seek new supports to meet a need? For example, if I want someone to talk to, are there people I know, or people around me, whom I could start spending time with?
- 3. Find the Right Time.** Because you'll be talking to the person about something that matters to you, you want him/her to have enough time to listen. Choose the right time and place to approach the person.
 - 4. Request With an "I"-Message.** Once you have decided what type of support you wish to receive, whom to ask, and have found a good time to talk, use an "I"-message to communicate the following:
 - How you're feeling
 - About your situation
 - What you want him/her to do

For example, you might say, 'I'm really angry about what happened at work today, and I just want to tell you about it.'
 - 5. Thank the Person.** End the conversation thanking the person for listening or how you were helped. Be specific so he/she knows how to help in the future.

Before we move on, does anyone have any questions about getting support? Okay, let's talk about giving support to others and words and phrases you can use to show your support.

Buddy Care - Supporting Your Buddy

Learning Objectives

- To understand the basic skills for supporting others
- To learn ways that you can model support

There are five basic steps to learning to provide support to others:

- 1. Identify the type of problem the person is facing.** Be sensitive to the type of problem that he/she is facing. Is he/she feeling sad or discouraged? Does he/she need help doing something, like repair something that is broken? Does he/she need someone who can help

clean something up or run an errand?

2. **Identify the type of support you can provide that would be helpful.** Think about the types of support that you can provide, or get others to provide, that would help the person. This may involve helping directly with the problem (like helping to carry something or to fix something), but it may also involve helping to get his/her mind off things, like going for a walk, seeing a movie, or doing something together. As you think this through, consider your limits as to how much help you can realistically provide. Be careful not to overburden yourself by taking on too much. If the problem is a difficult one, and the person needing help agrees, invite other people to help.
3. **Find the right time.** Because you'll be talking to the person about something that matters to him/her, find a good time to talk when he/she can listen to you. For example, you can ask, "Do you have the time to talk right now?"
4. **Offer to help.** Once you have found a good time to talk, tell him/her that you care and you would like to help. Be careful not to make him/her feel uncomfortable by implying that he/she isn't handling things well.
5. **Provide help in a sensitive way.** Finally, if he/she agrees to receive support, provide it in a sensitive way. Pay attention to which types of help he/she wishes to receive, when he/she wants help, and how much help he/she wants. Be gracious---if he/she thanks you then say you are welcome.

Modeling Support

The way you respond to buddies who are seeking help can be important. Negative support such as minimizing problems or needs, providing unrealistic expectations, or invalidating messages can be undermining. You can help buddies by providing positive and supportive comments such as:

Reflective comments:

- “From what you're saying, I can see how you would be...”
- “It sounds like you're saying...”
- “It seems that you are...”

Clarifying comments:

- “Tell me if I’m wrong … it sounds like you …”
- “Am I right when I say that you …”

Supportive comments:

- “No wonder you feel….”
- “It sounds really hard….”
- “It sounds like you’re being hard on yourself.
- “It is such a tough thing to go through something like this.”
- “I’m really sorry this is such a tough time for you.”
- “We can talk more tomorrow if you’d like.”

Empowering Comments and Questions:

- “What have you done in the past to make yourself better when things got difficult?”
- “Are there any things that you think would help you to feel better?”
- “I have an information sheet with some ideas about how to deal with difficult situations. Maybe there is an idea or two here that might be helpful for you.”
- “People can be very different in what helps them to feel better. When things get difficult, for me, it has helped me to… Do you think something like that would work for you?”

Barriers to Care

If individuals are reluctant to seek support, there may be many reasons, including:

- Not knowing what they need (and perhaps feeling that they should know)
- Feeling guilty about receiving help when others are in greater need
- Not knowing where to turn for help
- Fearing that they will get so upset that they will lose control
- Fearing the people they ask will be angry or make them feel guilty for needing help
- Worrying that they will be a burden to others
- Doubting that support will be helpful or not trusting mental health professionals
- Having tried to get help and finding that help wasn’t there (feeling let down or betrayed)
- Not being able to afford or access help

Some Soldiers are reluctant to seek needed help because they are concerned about:

- Feeling embarrassed or weak because of needing help
- Fearing unit leadership would treat them differently

- Concern that it would harm their career
- Feeling fellow Soldiers would have less confidence in them
- Believing that they would be blamed for the problem (rather than blaming difficult events)
- Thinking, “No one can understand what I’m going through”

You can be of assistance by helping a buddy in need to:

- Think about the type of support that would be most helpful
- Think about who they can approach for that type of support
- Choose the right time and place to approach the person
- Talk to the person and explain how he/she can be of help
- Encourage and support their decision to seek help

After difficult events, some people choose not to talk about their experiences. In these instances, the focus of support should not be on discussing the difficult event or loss, but rather on providing practical assistance and problem-solving current needs and concerns. Even if difficult events are not discussed or no talking takes place at all, spending time with people one feels close to can feel good.

We want to get some feedback about our last workshop. When we met last month, we talked about basic coping skills, anger management, sleep problems and safety. Did you find this information useful? Did you do handle a problem differently based on what you learned in the last workshop?

Conclusion/Close

Well we are out of time so we'll end our discussion. Great participation today! You provided great examples of challenges and use of PFA to work through them. Don't hesitate to call our toll-free telephone information line (1-866-553-5808), visit the website (www.TeamTrainingOnline.org), or e-mail us directly (info@TeamTrainingOnline.org) for additional assistance. We'll see you next month.

----- End Workshop 2 -----

WORKSHOP 3

(Approximately 4 months post deployment)

Outline

FIRST HOUR

A. MA TEAM assessment

- The Usual Services Group is excused →
- Workshop Group break

SECOND HOUR (Start of Workshop 3 training)

A. Efficacy

B. Problem Solving

- Buddy Care—Problem Solving

C. Positive Activity Scheduling

THIRD HOUR

A. Hope/Optimism

B. Helpful Thinking

- Buddy Care—Helpful Thinking example

Introduction

“Well here we all are one more time. Thanks, as always for taking time to complete the surveys. You all have been through, and continue to go through, a lot. We are honored that you have chosen to share your experiences with us, and we hope we are increasingly on track with our suggestions. We will stay with our usual format here beginning with a brief review, introducing one, and then another of the principles of PFA in more detail.

This educational program is based on the concept of Psychological First Aid (PFA), a set of recommended principles developed by the National Center for PTSD, the National Child Traumatic Stress Network, and others for assisting people after disasters and other traumatic events. We have adapted the PFA principles to make them applicable to Soldiers and their spouses in dealing with adjustments associated with the return from deployment. Let’s begin by talking about self and collective efficacy.

Efficacy: Self and Collective Efficacy

Self-efficacy is the belief in one’s own capacity to achieve certain goals. An individual with high self-efficacy will believe that actions he or she takes towards a goal will result in success. Because of this positive belief, the individual will be more likely to make consistent and

organized efforts in the direction of his/her goal.

Collective efficacy is the belief that group goals are attainable. You may be familiar with concepts of self- and collective efficacy from your training for carrying out missions --- you learned to have confidence in yourself, your leaders and the group as a whole.

Self-efficacy can be built by learning problem-solving skills, helpful and optimistic thinking, and through demonstrations of how individuals, families and groups can work together to overcome adversity.

As we talk about various skills today, keep in mind that by learning these skills you are filling your personal toolbox with new tools that will be helpful when facing difficult events. Ultimately, learning these new skills can strengthen your belief in your ability to handle problems and achieve goals --- in short, increase your self-efficacy.

We will now discuss problem-solving skills and then move on to talk about the skills of positive activity scheduling.

Problem Solving

*******Provider instruction:** Distribute handout: *Problem-Solving*

Sometimes people experience times when it seems that there are so many problems that it is hard to figure out what to do. There is so much pressure to do something that it can be hard to step back and think carefully about what are the best things to do. It can therefore be helpful to use a systematic way of focusing on one problem at a time and carefully considering and choosing your actions. Today we are going to teach you a simple 3-step way to tackle any kind of problem that you want. Problem solving is a particularly useful tool because it can be used to think about reducing stress reactions, address interpersonal problems, and respond to practical obstacles to desired outcomes. If you use it, it can help you cut problems down to size and tackle your challenges successfully.

We are going to work through a model problem using the three steps, to give you an idea of how it works. We will come up with some possible things that can be done to work on the problem, and at the same time you'll be learning a tool that you can use for any other kind of problem that you're facing. Does that make sense? Any questions? Okay, what problem would you like to use

as our model problem?

*******Provider note:** you should understand enough about the problem to decide if it is a good choice for problem solving.

OK, the three steps are, first, to define the problem; second, to come up with a list of possible solutions; and third, to decide which ones to use and then go try them.

1. Define the Problem - Defining the problem carefully is important because if the problem is described in a clear and concrete way, it will be easier to identify practical steps toward solution. Before you can solve a problem, you have to have a clear idea of what the problem is. The more specific you can be about what the problem is, the easier it will be come up with ideas that will help to solve it.

Often, what seems like a big problem can be broken down into smaller problems that are easier to solve. Be specific when defining the problem. Most big problems can be broken down into smaller ones and these are much easier to solve. Also, the idea is to stay focused on one problem at a time. When problem solving, it is very easy to get into your other problems. Try not to do this. You can deal with another problem later in the same way.

So, how would you define our problem with _____?

*******Provider note:** Help the Soldiers define the problem in a way that is concrete and suggests ways to solve it.

It is important to write things down as you work through a problem. So, let's take a minute and write down our definition of the problem.

2. Make a List of Possible Solutions - Making a written list of possible responses/solutions is especially important. It will help you get off of "automatic pilot" and think about ideas that you might not ordinarily consider, and if you can make a list, it will help you see that you have more control than you might think, that you have some options for what you can do to make the situation a little better and cut the problem down to size. If you write your list down, you also won't lose your good ideas. The idea here is to "brainstorm" and list as many responses as possible. Often, first ideas about solutions are not the best, and having a list of possible actions can make the problem seem more solvable. The goal is to come up with ideas, and not worry

about how effective they will be; so write down any idea you have, including ones that might seem silly. Try to come up with as many solutions as you can. Don't try to judge them yet. Be very specific.

So let's consider our problem with _____. What are some things you can do to help solve it? As we come up with ideas, we will write them down.

*******Provider note:** As solutions are generated, you can suggest additional ideas and assist with the shaping and modification of ideas.

Types of solutions that may be relevant include:

- Ways of changing the situation
- Taking action on parts of the problem that are controllable
- Solutions that extend or build on things that are already helping
- Learning new skills for difficult situations
- Ways of calming oneself
- Helpful things to say to oneself
- Getting help/support from other people
- Getting additional services (Knowing what services are available ahead of time will help with solution generation and ensure that use of relevant available services can be considered for inclusion in the list)

You should end this phase of problem solving when at least 10 ideas have been listed, when there are several practical and useful ideas on the list, and when you are "running dry" of ideas. What do you think of our list of possible solutions?

3. Choose Best Solutions - OK, the final step is to go back through your list of solutions and choose the BEST actions. You can get rid of any solutions that don't seem helpful and pick some solutions that seem reasonable, that you think might help, that you would be willing to do, and you would like to put into action. As you pick some good possible solutions, you will want to circle them on your written list.

Which actions look especially good to you? You may choose several actions depending on the problem. It is important that you take relatively small steps and not make an unrealistic commitment. You must be able to follow through with the actions and the items you choose should be ones that have some real impact on the problem, even if it is a small impact.

*******Provider instruction:** Engage in a discussion of the pros and cons of the various choices. Choose several of the best actions from the model problem.

That's how you do problem solving. Remember that this problem solving technique will work for all kinds of problems. It will help to practice the three-step technique for it to work, but also remember there are benefits to seeking help from others when you require assistance.

Buddy Care - Helping Buddies Solve Problems

*******Provider instruction:** Distribute handout: *Helping Your Buddy Solve Problems*

You can help your buddy with problem solving. When buddies are facing adversity, providing them with needed resources can increase a sense of empowerment, hope, and restored dignity. Therefore, assisting your buddy with current or anticipated problems is very helpful. Fellow Soldiers may welcome a pragmatic focus and assistance with problem solving.

Learning Objectives

- To learn how to offer practical help through problem solving for buddies' immediate needs and concerns

As much as possible, help your buddy address identified needs, as problem-solving may be more difficult under conditions of stress and adversity. Teaching individuals to set achievable goals may reverse feelings of failure and inability to cope, help individuals to have repeated success experiences, and help to reestablish a sense of environmental control.

Step 1: Identify the Most Immediate Needs - If a buddy has identified several needs or current concerns, it will be necessary to focus on them one at a time. For some needs, there will be immediate solutions (for example, getting something to eat). Others (for example, returning to previous routines after deployment or acquiring needed health care) will not be solved quickly, but your buddy may be able to take concrete steps to address the problem (for example, setting an appointment for health care services). As you work with your buddy, help him/her select issues requiring immediate help.

Step 2: Clarify the Need - Specify the problem. If the problem is understood and clarified, it will be easier to identify practical steps that can be taken to address it.

Step 3: Discuss an Action Plan - Discuss what can be done to address your buddy's need or concern. Your buddy may say what he/she would like to be done, or you can offer a suggestion. If you know what services are available ahead of time, you can help obtain financial assistance, medical or mental health care, spiritual care services, or more simple items such as food. Discuss what can be expected in realistic terms.

Step 4: Act to Address the Need - Help your buddy to take action. For example, help him/her set an appointment with a needed service or assist him/her in completing paperwork.

If you are helping buddies problem solve, and they doubt their ability to overcome obstacles, reminding them of their successes in solving problems in difficult situations of the past. This process of borrowing personal strengths and successful accomplishments of the past may be more helpful than trying to build new strengths for the current obstacles.

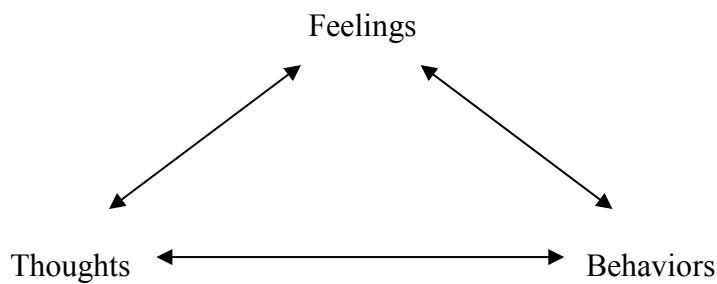
Positive Activity Scheduling

After difficult events, it is very common for people to stop doing things that used to be enjoyable, rewarding, or personally meaningful. This may be because 1) they are too busy with other problems caused by the events such as dealing with financial problems or helping loved ones, 2) they just don't feel like it anymore, or 3) they are avoiding places or situations because they bring up event-related feelings. Regardless of the reason why, we know that people feel sad, withdrawn, or apathetic when they no longer engage in pleasurable activities.

Learning Objectives

- To understand how scheduling positive activities can increase positive emotions

Let's spend a few minutes talking about the rationale for positive activity scheduling. Feeling sad, withdrawn or apathetic is common after difficult events. However, when these feelings become long lasting, they begin to interfere with the rest of your life. One explanation for feeling this way is that it results from, and is maintained by, having more negative experiences than positive ones. Positive experiences tend to cause positive emotions, whereas negative experiences tend to cause distressing emotions. Therefore, if you want to improve your mood, you need to increase positive experiences and decrease negative ones. Another way to think about this is to understand that our personalities are made up of our thoughts, feelings, and behaviors (*Show diagram*).



Feeling sad, withdrawn, or apathetic can come from any of these areas --- feelings, thoughts, or behaviors. In addition, each area affects the other two areas. When people feel down, often the first thing that they attempt to change is their feelings. This makes sense because the goal is to feel better. However, feelings are actually the most difficult of these three areas to control and change. As you have probably discovered, simply telling yourself to feel good usually does not work. In fact, it is easier to change your thoughts and behaviors, which will in turn change the way you feel. To help you to feel better, you can add positive activities into your life. You may already feel highly taxed and the idea of adding more activities to your current schedule may be stressful. If you regularly engage in many pleasant activities, it may be less important to schedule new positive events. If not, this skill might be very important for you.

Selecting and Scheduling Positive Activities - When thinking about activities you would like, consider activities that you think you would enjoy and that you think you would actually do. The activities should be meaningful, enjoyable, fun and/or lead to a sense of contribution or mastery. Consider activities from a range of areas. For example:

- Sports (soccer, tennis, running)
- Outdoors (camping, BBQ, hiking, fishing)
- Entertainment (movies, reading, computer games)
- Hobbies (woodworking, model making, work on collections)
- Clubs/Organizations (volunteering, joining a club of interest, coach a youth sports team)
- Social/Family (play card games, board games, Frisbee, or any of the activities above with a family member, e.g., family fishing, BBQ or reading a book as a family)

You might choose to do one new activity with your spouse/significant other, one with your children (or other family), one with a buddy, and one alone. Can you think of three or four positive activities that you can do this week?

Now what we know from working with people who are sad, withdrawn, or apathetic is that it is not enough just to tell yourself to do more things that are positive. The reason for this is that when you feel down, you often feel immobilized, have trouble making decisions, or are exhausted. Therefore, it is unlikely that you will feel like you have the energy or determination to get out there and do pleasant things. You may feel like you can't imagine ever having fun again or that you don't deserve to have fun in your life after the events that you have been through. In order to increase the chances of following through with the activities, you can use a calendar to schedule the activities and then follow your schedule. Remember, even if you don't feel like engaging in positive events due to feeling of sadness or lack of energy, it is important that you engage in some.

“OK, maybe we’ll be able to track how that activity scheduling works out at our booster workshop in three months. We have one more principle to go over. Let’s take a short break.

Break #1

Hope/Optimism

What is hope and why is it important?

- Hope is defined as “a positive, action-oriented expectation that a positive future goal or outcome is possible.”
- It is also considered a thinking process that taps a sense of agency and the awareness of the steps necessary to achieve one’s goals.
- Hope can be a religious belief.

Exposure to difficult events is often accompanied by a loss of hope. Difficult events may destroy one’s positive views of the world or overwhelm one’s ability to cope. Those who are more likely to have favorable outcomes following difficult events are those who maintain one or more of the following characteristics:

- Optimism (because they can have hope for their future)
- Confidence that life is predictable
- Belief that things will work out as well as can reasonably be expected
- Belief that outside sources act benevolently on one’s behalf (God, community, government)
- Strong faith-based beliefs
- Positive belief (for example, “I’m lucky, things usually work out for me”)

- Practical provisions, including housing, employment, financial resources

*******Provider note:** Employment status is the primary predictor of hope in combat veterans. (It is important for MA Soldiers to see themselves as usefully employed.)

Ways to improve hope and optimism include:

- Identify, amplify, and concentrate on building strengths
- Envision a realistic outcome even if the outcome may be difficult
- De-catastrophizing – not looking for or expecting the worse to happen
- Find benefit - look for the good that one can make of a difficult situation
- Use helpful thinking techniques to reduce irrational fears, control self-defeating behaviors, reduce your sense of personal responsibility for the difficult event and encourage positive coping

Helpful Thinking

After difficult events, it is common for people's appraisals about the world and themselves to change. For example, it is common to see the world as dangerous, stressful, or difficult. An individual might have trouble trusting other people or see oneself as unable to cope.

Most often, the changes in someone's views are extreme and not entirely accurate. These new appraisals can be hard to change unless people become aware of them. They can then learn to challenge them with appraisals that are more realistic.

How Thoughts Influence Feelings - Certain situations seem to make people react in certain ways. For example, being stuck in traffic might make someone feel angry. However, what is important about a reaction to a situation is not so much the circumstances of the event, but the thoughts a person has about the situation. If someone was stuck in traffic and he/she were thinking, "This is going to make me late and my boss will really punish me" they may feel anxious. On the other hand, if they were thinking, "Why am I always stuck behind stupid drivers?" they may feel frustrated and irritable. Alternatively, if they were thinking, "At least I'll miss that boring morning meeting," they may feel happy that they are in that situation.

Example event: Getting stuck in traffic

1a) ***Appraisal:*** I'm going to be late and get in trouble

1b) ***Emotion:*** Anxiety

2a) ***Appraisal:*** Why do I always get stuck behind stupid drivers?

2b) ***Emotion:*** Frustration

3a) ***Appraisal:*** I'm going to miss the boring morning meeting

3b) ***Emotion:*** Happiness

People's appraisal of the situation results in an emotional experience. Appraisals are different from feelings. They are the thoughts or beliefs about the situation that run through people's heads. Emotions result from the appraisals.

For people to change their emotional reactions, they need to change their appraisals about the things that happen to them. This is achieved in several steps:

1. Understand how appraisals influence your emotions
2. Increase awareness of the appraisals that cause you to have excessive negative feelings
3. Identify the emotions you feel when you make an appraisal that is not accurate
4. Replace the appraisals with more helpful thoughts, which will lead to new emotions

Let's look at this table that shows some of the more common unhelpful appraisals that lead to some of the emotional distress experienced after difficult events. Most people's thoughts will fall under the themes in the table below (e.g., relating to safety, control, blame). The table also includes some examples of alternative appraisals that can lead to less emotional distress.

Unhelpful Appraisals	Resulting Emotions	Alternative Appraisals	New Emotions
Control			
"I have no control over anything"	Helplessness; apathy; confusion; frustration	"I can control some decisions about my future" "Doing things gives me a greater sense of control" "Talking to someone about my problems shows I have some control"	Purposeful; hopeful; goal-oriented; less helpless
"I can't cope"	Helplessness; incompetency; fear	"The fact I got here today says I am coping a bit" "Everybody will have trouble after this event"	Less fearful; less helpless; oriented to seek support/help
Safety			
"The world is a dangerous place"	Scared; anxious; mistrustful	"The world can offer good possibilities" "The world is not always dangerous" "There are good people as well as bad in the world" "Most of the time I am safe"	Hopeful; active about future; trusting of people who will help
"I can't trust anyone"	Lonely; withdrawn; suspicious; sad	"Trusting people has led to me getting help" "I don't need to be mistrustful of everyone" "I can choose some people to trust"	More trusting, less suspicious; hopeful; optimistic
"I'm not safe"	Anxious; fearful; Insecure	"Feeling unsafe isn't the same as being unsafe" "A bad thing has happened but it doesn't mean it will happen again"	More relaxed; self-assured
Blame			
"This is unfair"	Angry; vengeful	"This could have happened to anyone" "Sometimes bad things happen to good people"	Understanding; realistic; resigned
"I should have prevented this"	Guilty; frustrated; low self-esteem; upset	"Nobody could have prevented this" "I can't always protect others"	Accepting; intact self-esteem
"I should have done more"	Guilty; frustrated; upset	"At the time I did the best I could" "I would not expect anyone else to have done more than I did"	Able to move on; reduced distress
"It's their fault this happened"	Angry; frustrated; vengeful; mistrust	"Blaming people doesn't change my situation"	Accepting; optimistic
"Things will never be the same again"	Sad; regretful; hopeless	"Feeling really bad usually doesn't last forever" "Thinking like this makes it difficult to plan for the future"	Future-oriented; accepting

Making appraisals that leave you depressed, anxious, or feeling helpless is understandable but leads to not being able to act in a helpful way. If the appraisals can be changed, and in turn, the emotional consequences are less negative, you are more likely to feel stronger, more in control and ready to plan for the next step.

Changing Unhelpful Thinking - The best way to change unhelpful thinking is to test your

thoughts against your own experiences. That is, if you believe that you cannot feel safe again, it is useful to state how much you believe you cannot feel safe. Then test this belief over the next week by seeing how often this came true. This is the most powerful way one can see whether thinking in a more realistic way is useful.

It can be helpful for you to rate your belief in the truthfulness of your thoughts on a scale of 0-100%, where 100% is absolute belief that the thought is true. Now, find a way to test the accuracy of this belief. You will need to find specific examples of how the difficult event has made you feel.

Buddy Care - Helpful Thinking for Buddies

We can see an example of changing unhelpful thinking in an interaction between Allen and one of his buddies.

Appraisal Example: "I'm not safe" - It is common for people to have a pervasive feeling that they are at risk or not safe following a difficult event. Often people overestimate their risk for harm. In the following example, Allen's buddy is reluctant to be in crowded places after a recent bomb explosion in a public marketplace. He reports a strong belief in not being safe when he is around crowds of people.

Allen: So you avoid public places?

Buddy: Yeah-I get really shaky when I'm near a lot of people. I know its stupid but I feel better even if I'm a block away from crowds.

Allen: But when you're a block away, you feel safe?

Buddy: Yeah, I feel ok. Not completely safe, but ok.

Allen: So when you're less than one block away what do you worry will happen?

Buddy: That a bomb will go off and I'll get injured or killed. When I get closer to a crowd of people I usually start freaking out.

Allen: Thinking you're not safe because a bomb could go off in the crowd and injure

you?

Buddy: Yeah.

Allen: If you want to test that appraisal, could you try standing close to a crowd and gather information about what happens when you are that close to a group of people?

Buddy: I could do that, but I would still feel quite freaked out if I was standing close.

Allen: If you're thinking, "I'm not safe" then you will begin to feel anxious and possibly freak out. What if you try getting close and replacing that appraisal with a new appraisal "Feeling unsafe isn't the same as being unsafe" and trying the process for just 10 minutes to start with. How do you think that would go?

Buddy: I may still freak out...I don't know.

Allen: Well that can be part of the information you gather. Try replacing your appraisal of "I'm not safe" with "feeling unsafe is not the same as being unsafe" and see what effect this has on your anxiety levels. Remember, you're only a few feet closer to the crowd and only staying there for 10 minutes. Ok?

Buddy: I'll give it a go.

Whether setting up and testing a new appraisal for yourself or a buddy, it is likely that you will meet with reluctance and resistance as Allen did in the case of helping his buddy. In these instances, it is important that you take part in the task (or when working with a buddy, encourage your buddy to take part) even if it's a situation that has been avoided for a long time. It may help to come up with a small first step that makes the task more manageable (e.g., staying for a short time and gradually increasing this, or getting gradually closer to the avoided situation). As the task helps you (or the buddy you are helping) gain evidence disconfirming the unhelpful appraisal, your confidence in testing further beliefs should improve. Acquiring these helpful thinking skills is like learning anything new; they will get better with practice. We encourage you to practice these helpful thinking skills on a daily basis.

OK, I am hopeful that these exercises have illustrated the importance and usefulness of maintaining a sense of hope or optimism even in the face of interpersonal or work-related

challenges. We have now spent time covering—in a fair amount of detail—the principles of PFA: Safety, Calming, Connectedness, Efficacy (self and community), and Hope. Let's take a short break and see if we can apply the skills learned today as well as those learned in our previous months to some current concerns. Everyone come on back in 10 minutes:

We would like to get your feedback about the material we covered in the last two workshops. You will recall that when we met two months ago, we talked about basic coping skills, anger management, sleep problems and safety. When we met last month, we talked about calming techniques, connectedness and barriers to care, and how you can help your buddies with each of these. We would like to know if you found this information useful.

- Have you used any of the PFA principles?
- Which PFA principles seem most important?
- Which PFA will you use later on?
- Did you share any PFA skills with others?
- Did you overcome any barriers to seeking care?
- Were you able to help a buddy or family?

Conclusion/Close

“Well once again it seems we’ve reached our time limit. This has been an excellent discussion. We really have covered a great deal of material in these three workshops; some philosophical but mostly practical things that can be applied to everyday challenges. We know everyday life can be challenging for anyone—but for folks such as you, who have sacrificed so much by spending time serving your nation, these everyday challenges can be magnified. We hope we’ve given you some tools to help bring these challenges back into perspective, to help address them in yourselves, your families, and in your buddies, and to help you recognize when and how to seek outside help and overcome the barriers to seeking that assistance. We will be back again—but not for another three months. In the meantime, please use the handouts, the toll-free telephone information line (1-866-553-5808), the web resources (www.TeamTrainingOnline.org), and the email service (info@TeamTrainingOnline.org) and stay in touch with us. We want you to be successful and we are there to help, when you want our help. Thanks again!

----- End of Workshop 3 -----

WORKSHOP 4

(Approximately 7 months post deployment)

Outline

FIRST HOUR

- A. MA TEAM assessment
 - The Usual Services Group is excused →
 - Break for Workshop Group

SECOND HOUR (Start of Workshop 4 training)

- A. Safety
 - Helping Your Buddies Feel Safe
- B. Calming
 - Helping Your Buddy Become Calm
- C. Connectedness
 - Supportive Connections with Your Buddies

THIRD HOUR

- A. Barriers to Care
- B. Efficacy: Self and Collective Efficacy
 - Problem Solving
 - Helping Buddies Solve Problems
- C. Hope/Optimism

Introduction

Good morning/afternoon. During the last six months, you have been involved in a series of workshops that focused upon issues and situations that often arise among Soldiers returning from a deployment and reestablishing garrison duties. Thank you for your cooperation and for the many concerns you have addressed during the workshops. We hope that the training has also been beneficial to you in dealing with any distress, health concerns or relationship issues.

Today's training is a "booster." We review of some of the materials we covered during the three previous workshops and reinforce the skills we wanted you to acquire during the training exercises. Just to remind you, this educational program is based on the concept of Psychological First Aid (PFA), a set of recommended principles developed by the National Center for PTSD, the National Child Traumatic Stress Network, and others for assisting people after disasters and other traumatic events. We have adapted the PFA principles to make them applicable to Soldiers and their spouses in dealing with adjustments associated with the return from deployment.

Learning Objectives

- To review key concepts of the TEAM (Troop Education for Army Morale) educational

program designed to meet the needs of mortuary affairs Soldiers returning from a deployment

- To reinforce the principles of Psychological First Aid (PFA) and skills acquired during the three previous workshops

As we have noted many times, the training program is based upon the concept of Psychological First Aid, which is developed for assisting people after they experience difficult events. We modified the program so that it would be applicable to Soldiers, their spouses and buddies dealing with issues that may arise following a deployment. The training emphasized five PFA principles, Safety, Calming, Connectedness, Self-efficacy and Hope/Optimism. These principles are designed to help us better cope with stressful events and better manage our reaction to such events. Before reviewing the principles of PFA, let's again look at the possible links between difficult events that we may experience and some of the reactions that may occur.

During the training, we used the term "difficult event" to describe any event that fell into the range of being mildly stressful to being very traumatic and challenging.

*******Provider instruction:** Ask the group to name difficult events. After they name a few, continue the presentation with brief comments regarding the following types of difficult events that occur.

- Natural disasters such as floods, earthquakes, hurricanes
- Man-made disasters such as industrial accidents, war
- Personal events such as relationship problems, financial problems, and family conflicts.

*******Provider note:** Reactions to difficult situation cover a wide range such as those associated with PTSD to those that may be less serious. Review the following three reactions that are usually associated with PTSD.

Intrusive reactions: The ways in which traumatic experiences come back to mind. These reactions include distressing thoughts or mental images of the event, or dreams about what happened.

Avoidance and withdrawal reactions: the ways people use to keep away from, or protect against intrusive reactions. These include trying to avoid talking, thinking and having feeling about the traumatic event.

Physical arousal reactions: These are physical changes that make the body react as if danger is still present. These reactions include constantly being “on the lookout” for danger, being jumpy or startling easily, anger, sleep and concentration difficulties.

*******Provider note:** Mention the following reactions to difficult events that the participants may be more familiar with. These are:

Grief reactions: feeling of sadness and anger or regret over a death.

Depression: loss of pleasure in life activities, hopelessness, suicidal thoughts,

Anxiety: worry, panic and fear

Then there are the physical reactions to difficult events that are experienced in the absence of any underlying injury or illness. These reactions may be due to stressors associated with day-to-day hassles and difficult events. Examples of such physical reactions are headaches, pains in the chest, feeling low or down, stomach aches, bowel/bladder problems, numbness/tingling, feeling weak, etc. Many of these physical reactions may be related to different aspect of stress. Such reactions are understandable and not unusual. However, if a person’s ability to function adequately continues for over a month, psychological services should be considered.

*******Provider instruction:** The group should be reminded of secondary adversities or events that may happen after the primary difficult event such as financial problems, legal problems, unexpected losses or changes in living or health situations. Such situations that may occur after a deployment can prolong stress and grief reactions and increase the risk of depression and hopelessness. Secondary adversities can greatly interfere with functioning at work, in the family, in romantic and interpersonal relationships and in the community. Ask the group to identify any secondary adverse situations that they experienced following their return from the deployment or in conjunction with the deployment.

Principles of Psychological First Aid

Safety

Safety is one of the five principles of psychological first aid. We shared some general ideas about safety and how it can affect many areas of your life. For example, we discussed things you can do to: 1) make judgments about your safety and the safety of others and, 2) how you might

deal with safety issues when you recognize them in yourself and in others.

Questions to the Group

- How would you define “a sense of safety?”
- How do you compare your current sense of safety with that you experienced during the deployment?
- Do you feel any particular threat to your safety in this garrison environment?
- What can we do or not do to improve our safety?

*******Provider instruction:** Use the following to review/reinforce the PFA principle of Safety

Usually, people have some belief in their sense of safety, some sense that their world will not come crashing down on them. This has been called the “bubble of safety” or “shield of confidence.” However, very difficult events such as a threat to life or limb can alter our sense of safety by bursting our bubble of safety or lowering our shield of confidence. In these situations, it may take some time before a sense of safety can be restored

Feeling safe is important. A psychologist Abraham Maslow proposed that everyone is motivated by a common hierarchy of needs. In the hierarchy, having a sense of safety is just above the most basic physiological and biological basic life needs for food, water, sleep, etc.

There are ways to increase your sense of safety. First, connect with and know your feelings and evaluate any threats or risks of harm so you can appropriately respond. A threat appraisal or an evaluation of your risk of harm can help you decide what action to take to improve your sense of safety. Such an appraisal may also help you recognize that you are not in an unsafe situation.

Another way to improve safety is to remove whatever is preventing you from feeling safe or to remove yourself from the environment where you feel unsafe. Because of your experiences while deployed you may feel unsafe in crowds or on bridges. However, here in the States, crowds and bridges do not carry the same risks for harm. Avoiding crowds and bridges altogether will not help you regain a sense of safety. Be careful not to link harmless images, people and things to dangerous stimuli associated with the original difficult event.

Sometimes, talking with others about why and when you are feeling unsafe may be supportive if it is limited and does not make individuals more anxious. Safety also involves safety from bad

news, rumors, and other interpersonal factors that may increase threat perception. Avoid the sharing of horror stories that may increase psychological distress.

Helping Your Buddies Feel Safe

Promoting safety can reduce distress and worry for your buddies. A sense of safety can be supported in a number of ways with your buddies. Buddy safety can be supported when you:

- Get current accurate and up-to-date information
- Get connected with available practical resources such as ACS
- Get connected with others who have shared similar experiences
- Do things that are active, practical, and familiar
- Avoid exposure to information that is inaccurate or excessively upsetting; this may include helping your buddies to limit their exposure to TV, movies, radios, certain sights and sounds

You can help your buddies reevaluate perceptions of threat by discussing the situation. This may involve:

- Challenging the perception of threat
- Emphasizing the positive ways in which your buddies faced and overcame a previous threat
- Acknowledging your buddy's reaction and expressing your understanding and interest in helping will go a long way in making your buddies feel accepted and cared for

Calm

*******Provider note:** It is very common for people who have experienced a difficult time to feel tense, anxious, overwhelmed with emotions and unable to stop thinking about or imagining what happened. These are normal and expected responses to difficult events. Extremely high arousal, numbing, or extreme anxiety can interfere with sleep, eating, decision making, parenting, work and other life tasks. Calming is a skill that can be used whenever tension and anxiety occur and is especially important when reactions are so intense and persistent that they interfere with one's ability to function.

We taught you some specific skills or techniques to help you calm yourself when tense, anxious or emotionally overwhelmed. We also taught you how to help your buddies remain calm. Before we review calming techniques, I would like to know if any of you have tried to use either the

breathing exercise or muscle relaxation exercise. If you have, tell us about the situation, the technique that you used and if you found the technique to be useful.

If no one has used either the breathing or muscle relaxation exercise, repeat the breathing exercise and muscle relaxation exercises and encourage participants to use them during times when they feel anxious or “on edge”

*******Provider instruction:** Use the following script for the breathing exercise:

Many people believe that taking a deep breath helps them calm down when they are stressed or anxious. However, contrary to this belief, taking a deep breath usually is not helpful and can actually lead to more feelings of anxiety. A good way to cope with anxiety is to take a normal breath and exhale slowly. While you exhale, try saying the word CALM or RELAX very slowly to yourself, like this, C-a-a-a-a-a-l-m. If you do not find the words “calm” or “relax” to be helpful, it is also fine to use the word “exhale” or some other word of your choosing.

In addition to exhaling slowly while saying “calm” to yourself, I want you to slow down your breathing. Very often, when people become frightened or upset, they feel like they need more air and may hyperventilate in response to that feeling. Hyperventilation does not have a calming effect. Hyperventilation tells our bodies to prepare for danger and causes feelings of anxiety. Unfortunately, when we are under stress, many of us hyperventilate without even realizing it. Unless we are preparing for a very dangerous situation, we often do not need as much air as we are taking in. If we want to calm down, what we really need to do is to slow down our breathing and take in less air.

*******Provider instruction:** Model how to inhale, exhale slowly saying, “CALM” pause and count to four and repeat. Then ask the Soldier to perform the exercise according to the following instructions.

Let’s practice: Focus on your breathing. Take a normal breath and exhale very slowly while silently repeating the cue word. Pause and count to four before taking the next breath. How did that go for you? Did you have any problems?

Remember, breathing exercises can be very useful in specific situations like:

- In times of high stress (e.g., traffic)
- When encountering reminders of difficult events

- When emotionally upset (e.g., after arguments with a spouse or family member)

Learn to use breathing exercises, especially when you are:

- Tense, irritable, anxious, frustrated or annoyed
- Shaky, trembling or feeling “keyed up”
- Feeling out of control or have the urge to escape your current situation
- Finding it hard to relax
- Not sleeping or have poor sleep
- Having difficulty concentrating

*******Provider instruction:** Check to see if anyone has tried the muscle relaxation technique. If so, have them model what they did and whether it was useful. Talk the Soldiers through the following progressive relaxation exercise:

- Sit comfortably in your chair and close your eyes
- Feel your feet, relax them, start with your toes and move up to your ankles
- Feel your knees, relax them and feel all of the tension go out of them,
- Feel your upper legs and thighs, relax them and feel them release any tension,
- Feel your abdomen and chest and sense your breathing, deepen your breathing, breath out any tension, breath in calmness and peacefulness.
- Feel your buttocks, relax and let it sink further into the chair, relax that tension and let the tension go
- Feel your hands and let them sink into your lap
- Feel your upper arms, your shoulders, your neck your head and skull, your mouth and jaw, your eyes and your face and cheeks. Relax them,
- You are now completely relaxed, mentally scan your body. If you find any place that is still tense, relax it as you sink into a deeper and deeper state of relaxation. As I count to ten, you will get more and more relaxed. Now slowly open your eyes and become aware of your surroundings.

*******Provider note:** The participants can be told that they can engage in self-talk and talk themselves through this type of progressive relaxation whenever they feel tense or anxious. For both those who develop more severe stress reactions and the general population of exposed individuals, ‘normalization’ of stress reactions is a key intervention principle to enhance calming. When individuals interpret their experiences in distressing ways, such pathologizing of their own common responses is likely to increase

anxiety associated with these reactions. Normalizing and validating expectable and intense emotional states and promoting survivors' capacities to tolerate and regulate them are important intervention goals at all levels. Disaster survivors should avoid pathologizing their inability to remain calm and free of the expectable intense emotions that are the natural consequences of such threatening and tragic events. In any such intervention, it should not be underestimated that people's agitation and anxiety are due to real concerns and actions that help them directly solve these concerns are the best antidotes for the vast majority.

Buddy Care- Helping Your Buddy Become Calm

In general, the following steps will help to calm most distressed individuals

- When you notice a buddy having problems ask how they are doing and if there is anything you can do to help
- Respect his/her privacy
- Remain calm, quiet and present
- Be available if the person needs additional help
- Offer support and helm the focus on manageable feelings, thoughts and goals

If your buddy is too agitated, and upset, shows extreme anxiety, fear or panic, consider doing the following:

- Take your buddy to a quiet place to talk
- Ask your buddy to listen to you and look at you
- Find out if he/she knows where he/she is and what is happening
- Enlist other buddies, family or friends in providing comfort to the distressed individual

Try to understand what your buddy is experiencing. Is he/she crying, panicking, experiencing a "flashback" or imagining that a difficult event is taking place? Address the person's primary immediate concern or difficulty rather than simply trying to convince them to "calm down" or "feel safe." **Make a referral to professional help if the situation does not improve.**

Connectedness

Connectedness with others includes seeking support and giving support to others. Social support is one of the most consistently identified protective factors for combating stress. After difficult events, a lack of connection with social supports may lead to loneliness and emotional distance,

which can increase the risks for problems such as PTSD.

Social support can help you in different ways:

- Increases opportunities for knowledge and problem solving
- Allows for sharing of experiences and concerns
- Feeling needed, wanted understood and cared for
- Feeling like you fit in and belong
- Build up your confidence that you can handle the problem you are facing.

There are times when seeking the help of others are vital:

- An acute medical problem that needs immediate attention
- An acute mental health problem (someone threatening harm to self or others)
- Domestic, child or elder abuse
- Significant developmental concerns about children or adolescents
- When pastoral counseling is desired
- Alcohol or drug problems
- Ongoing problems with difficult events (still having problems 4+ weeks after event)

Steps in Getting Support

1. **“What Do I Want?”** The first step is to figure out what you really want or need:
 - A. **Look Outside Yourself:** What kind of problem am I facing that I may need support from others to cope with?
 - B. **Look Inside Yourself:** What am I thinking and feeling inside that I may need support from others to cope with?
2. **“Whom Should I Ask?”** Think about who has been or could be a good source of support.
3. **Find the Right Time.** Choose the right time and place to approach the person.
4. **Request With an “I” Messages.** Use an “I” messages to communicate: how you are feeling about the situation and what you want the person to do.
5. **Thank the Person.** End the conversation thanking the person for listening or for how you were helped. Be specific so he/she knows how to help in the future.

Supportive Connections with Your Buddies

There are five basic steps to learning to provide support to others:

1. What kind of problem is the person facing?

2. What type of support can you provide?
3. What is the right time to talk to the person
4. Offer to help by showing that you care and would like to help
5. Provide help in a sensitive way

The way you respond to buddies who are seeking help can be important. Negative support such as minimizing problems or needs, providing unrealistic expectations, or invalidating messages can be undermining. You can help buddies by providing positive and supportive comments that are reflective (“It sounds like you are saying...”), clarifying (“tell me if I’m wrong...it sounds like you...”), supportive (“No wonder you feel..., it sounds like you are being hard on yourself”).

Barriers to Care

In spite of high levels of psychological distress associated with combat deployment and exposure to dangerous and difficult events, many active duty Soldiers fail to seek mental health care. If individuals are reluctant to seek support, there may be many reasons, including:

- Not knowing what they need
- Feeling guilty about receiving help
- Not knowing where to turn for help
- Feeling that they will get so upset that they will lose control
- Fearing the people they ask will be angry or make them feel guilty
- Worrying that they will be a burden to others
- Doubting that support will be helpful or not trusting mental health professionals
- Having tried to get help and finding that help was not there
- Not being able to afford or access help.

Barriers to Seeking Care in the Military

- Not trusting mental health professionals
- Not knowing where to get help
- Not having sufficient transportation
- Feeling it difficult to get an appointment
- Difficulty getting time off from work
- It costs too much money
- It would be too embarrassing
- It would harm my career
- The unit would have less confidence in me

- The unit leadership might treat me differently
- My leaders would blame me for the problem
- I would be seen as weak
- Mental Health care does not work

*******Provider instruction:** Conduct a brief reality check to see if the barriers to seeking care reflect myth or reality.

It is paramount that interventions identify those who lack strong social support, who are likely to be more socially isolated, or whose support system might provide undermining messages. Keeping them connected, training people how to access support and providing formalized support where informal social support fails will be important.

After difficult events, some people choose not to talk about their experiences. In these instances, the focus of support should not be on discussing the difficult event or loss, but rather on providing practical assistance and problem-solving current needs and concerns. Even if difficult events are not discussed or no talking takes place, spending time with supportive people can be extremely helpful.

Efficacy: Self and Collective Efficacy

Self-efficacy is the belief in one's own capacity to achieve positive and successful outcomes. Because of this positive belief, the individual will be more likely to make consistent and organized efforts in the direction of his/her goal.

Collective efficacy is the belief that group goals are attainable. Self-efficacy can be built by learning problem-solving skills, helpful and optimistic thinking, and thorough demonstrations of how individuals, families and groups can work together to overcome adversity. Learning problem-solving skills can strengthen your belief in your ability to handle problems and achieve goals.

Problem Solving

Problem solving is a useful tool because it can be used to think about reducing stress reactions, addressing interpersonal problems, and respond to practical obstacles. It can help you cut problems down to size and successfully tackle many challenges.

What are the three steps we learned that are components of the problem solving process?

- Define the problem so it can be expressed in a clear and concise manner
- Make a list of possible solutions. The goal is to come up with ideas and not worry about how effective they will be.
- Choosing the best solution. You can get rid of any solutions that do not seem helpful and pick solutions that seem reasonable

Remember that the problem solving technique will work for all kinds of problems. However, it will help to practice the three step process for it to work.

Helping Buddies Solve Problems

You can help your buddies with problem solving. When buddies are facing adversity, providing them with needed resources can increase a sense of empowerment, hope and restored dignity. Fellow Soldiers may welcome a pragmatic focus and assistance with problem solving.

As much as possible, help your buddy address identified needs because problem solving may be more difficult under conditions of stress and adversity. Teaching individuals to set achievable goals may reverse feelings of failure, an inability to cope, help individuals to have repeated success experiences, and help to reestablish a sense of control.

Steps in helping your buddies solve problems

1. **Help to identify your buddy's most immediate needs:** If a buddy has identified several needs, it will be necessary to focus on them one at a time.
2. **Clarify the need:** Specify the problem. If the problem is understood, and clarified, it will be easier to identify practical steps that can be taken to address it.
3. **Discuss an action plan:** Your buddy may say what he/she would like to be done, or you can offer suggestions. Discuss what can be expected in realistic terms.
4. **Act to address the need:** Help your buddy to take action. For example, help him/her set up appointments.

If you are helping buddies problem solve, and they doubt their ability to overcome obstacles,, reminding them of their successes in solving problems in difficult situations in the past may be useful. This process of borrowing personal strengths and successful accomplishments of the past may be more helpful than trying to build new strengths for the current obstacles.

Hope/Optimism

What do we mean by the psychological first aid principle of “Hope/Optimism.”?

- Hope is defined as “a positive, action-oriented expectation that a positive future goal or outcome is possible.
- It is also considered a thinking process that taps a sense of agency and the awareness of the steps necessary to achieve one’s goals.
- Hope can also revolve around one’s spiritual beliefs, having a responsive government or just the belief that things will be all right and work out

Those who are more likely to have favorable outcomes following difficult events are those who maintain one or more of the following characteristics:

- Optimism (Someone will always be there)
- Confidence that life is predictable
- Belief that things will work out as well as can be expected
- Belief that outside sources act benevolently on one’s behalf (God, community, government)
- Strong faith-based beliefs or the belief that one is lucky
- Hope can be enhanced when individuals are helped to get their lives back together (housing, employment, replaced household goods, etc)

Skills to improve Hope and Optimism

- Identify, amplify, and concentrate on building strengths
- Envision a realistic outcome even if the outcome may be difficult
- Decatastrophize, not looking for or expecting the worse to happen
- Find benefit, look for the good that one can make of a difficult situation
- Use helpful thinking techniques to reduce irrational fears, control self-defeating behaviors, reduce ones sense of personal responsibility for the difficult event and encourage positive coping.

Break #1

We would like to get your feedback about the material we covered in the previous workshops. You will recall that when we met for our first workshop we talked about basic coping skills, anger management, sleep problems and safety. When we met for our second workshop, we

talked about calming techniques, connectedness and barriers to care. When we met for our third workshop, we talked about Hope/Optimism, helpful thinking, problem solving, and positive activity scheduling. In each prior workshop, we talked about how to apply the skills to your life as well as how to help a buddy. Again, we would like to know if you found this information useful.

Questions about PFA and other program content:

- Have you used any of the five PFA principles?
- Which PFA principles seem most important?
- Did you use any of the techniques such as relaxation, helpful thinking, problem solving?
- Did you find that you thought differently about a problem based on what you have learned?
- Which PFA will you use later on?
- Did you share any PFA skills with others?
- Did you overcome any barriers to seeking care?
- Were you able to help a buddy or family?

Questions about the TEAM program:

- Overall, was what you learned helpful?
- Do you have questions that we did not discuss?
- Were our responses to questions helpful?
- What did you think of the evaluations?
- Would you encourage others to attend TEAM?
- What are your recommendations for future workshops?

Conclusion/Close

*******Provider instruction:** Distribute handout: *The Bottom Line*

We have one more handout that I want to mention before we end today. It is the handout called “The Bottom Line.” This handout has just five final thoughts that I would like to leave with you today. Let’s look at it...

We have reviewed and reinforced the five core principles of Psychological First Aid focused upon meeting some concerns of mortuary affairs Soldiers returning from a deployment in which

they were exposed to combat and stressful combat deployment events. The principles of Safety, Calming, Self-efficacy, Connectedness and Hope/Optimism are applicable to all levels of intervention, from those focusing on the individual to those that are community based. We are grateful for your participation in the educational process. Are there any questions?

*******Provider instruction:** Distribute handouts:

- *Helpful Coping Strategies*
- *TEAM Take Home Points*
- *Following Medical Recommendations for Health*

----- End of Workshop 4 -----

HANDOUT LIST

Orientation: Topics: Recruitment, Resources, Safety

- *Letter for Soldiers to Give to Command*
- *Contact Information Card*
- *Resources at Fort Lee and Wallet Card (for Usual Services Group)*
- *Resources at Fort Lee and Wallet Card (for Workshop Group)*
- *Letter of Introduction to Spouses*
- *Childcare Information*
- *Five Principles of Psychological First Aid*
- *Returning Home: Advice for Soldiers*

Workshop 1: Topics: PFA, Common Reactions, Coping, Family, Anger, Sleep, Alcohol, Safety

- *Common Reactions when Dealing with Difficult Events*
- *Alcohol, Medication and Drug Use after Difficult Events*

Workshop 2: Topics: Calming, Connectedness, Barriers to Care

- *Calming Techniques*
- *Connecting with Others: Giving Social Support*

Workshop 3: Topics: Self-Efficacy (Problem Solving, Positive Activity Sched), Hope (Helpful Thinking)

- *Problem-Solving*
- *Helping Your Buddy Solve Problems*

Workshop 4: Topics: Review of all previous topics

- *Helpful Coping Strategies*
- *TEAM Take Home Points*
- *Following Medical Recommendations for Health*
- *The Bottom Line*

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Appendix C – Intervention Handouts

- C1. Orientation Session – Letter for Soldiers to Give to Command (Intervention Group)**
- C2. Orientation Session – Letter for Soldiers to Give to Command (Comparison Group)**
- C3. Orientation Session – Resources at Fort Lee (Intervention Group)**
- C4. Orientation Session – Resources at Fort Lee (Comparison Group)**
- C5. Orientation Session – Wallet Card**
- C6. Orientation Session – Childcare Information**
- C7. Orientation Session – Five Principles of Psychological First Aid**
- C8. Orientation Session – Returning Home for Soldiers**
- C9. Intervention Session 1 – Common Reactions When Dealing with Difficult Events**
- C10. Intervention Session 1 – Alcohol, Medication, and Drug Use after Difficult Events**
- C11. Intervention Session 2 – Calming Techniques**
- C12. Intervention Session 2 – Connecting with Others**
- C13. Intervention Session 3 – Problem Solving**
- C14. Intervention Session 3 – Buddy Care: Helping Your Buddy Solve Problems**
- C15. Intervention Session 4 – Helpful Coping Strategies**
- C16. Intervention Session 4 – TEAM Take Home Points**
- C17. Intervention Session 4 – Following Medical Recommendations for Health**
- C18. Intervention Session 4 – The Bottom Line**

C1. Orientation Session – Letter for Soldiers to Give to Command (Intervention Group)

Workshop Group

TO: Commander
Department of the Army
Headquarters, 49th Group
3300 B Avenue, Building 9305A
Fort Lee, VA 23801-5119

SUBJECT: Participation in Research Study by Participants

Dear Sir or Ma'am:

This letter is to inform you that I have volunteered to participate as a member of the Workshop Group in the research study entitled "Mortuary Affairs Soldiers: Early Intervention and Altering Barriers to Care for Traumatic Stress and PTSD" conducted by Carol S. Fullerton, PhD, David M. Benedek, MD, Robert J. Ursano, MD, Quinn Biggs, PhD, and James E. McCarroll, PhD.

Taking part in this study as a member of the Workshop Group will involve participation in an educational program based on the principles of psychological first aid and taking a brief survey. This program will be conducted through a series of workshops held at Fort Lee. The workshops will last approximately 3 hours, from 0900-1200 or 1300-1600, subject to military requirements. The scheduled dates for these workshops, also subject to military requirements, are at approximately 1, 2, 3, and 6 months. The final meeting, at 9 months, is an evaluation and feedback session that will last approximately one hour.

Thank you for allowing me the time to attend this program.

Respectfully,

Signature

Date

Printed name

C2. Orientation Session – Letter for Soldiers to Give to Command (Comparison Group)

Usual Services Group

TO: Commander
Department of the Army
Headquarters, 49th Group
3300 B Avenue, Building 9305A
Fort Lee, VA 23801-5119

SUBJECT: Participation in Research Study by Participants

Dear Sir or Ma'am

This letter is to inform you that I have volunteered to participate as a member of the Usual Services Group in the research study entitled "Mortuary Affairs Soldiers: Early Intervention and Altering Barriers to Care for Traumatic Stress and PTSD" conducted by Carol S. Fullerton, PhD, David M. Benedek, MD, Robert J. Ursano, MD, Quinn Biggs, PhD, and James E. McCarroll, PhD.

Taking part in this study as a member of the Usual Services Group will involve taking a brief survey from approximately 0900-1000 or 1300-1400, subject to military requirements. The scheduled dates for these meetings, also subject to military requirements, are at approximately 1, 2, 3, and 6 months. The final meeting, at 9 months, is an evaluation and feedback session that will last approximately one hour.

Thank you for allowing me the time to attend this program.

Respectfully,

Signature _____

Date _____

Printed name _____

C3. Orientation Session – Resources at Fort Lee (Intervention Group)



Troop Education for Army Morale



RESOURCES

SERVICES ON FORT LEE

Army Community Services:
804-734-6388 & 800-507-7464
Family Advocacy Program: 804-734-7585
Sexual Assault Prevention: 804-894-0029
Soldier and Family Assistance Center: 804-734-6445

Kenner Army Health Clinic: 804-734-9000
Appointment Line: 866-645-4584
Patient Advocate: 804-734-9512
Behavioral Health: 804-734-9623
Social Work Services: 804-734-9152
Substance Abuse Counseling (ASAP): 804-734-9601
Referral Management: 804-734-2273
Tricare: 877-TRICARE or 877-874-2273

SERVICES OFF FORT LEE

Military One Source: 800-342-9647

Emergency Care Facilities:
Southside Regional Medical Center: 804-765-5000
Psychiatric Services: 804-765-5530
John Randolph Medical Center: 804-541-1600
Psychiatric Services: 804-541-7747

Psychiatric Services:
Virginia South Psychiatric & Family Services
804-541-0918

National Crisis Lines:
National Suicide Prevention Lifeline: 800-273-TALK
National Alcohol & Drug Helpline: 800-662-HELP
National Child Abuse Hotline: 800-4-A-CHILD
National Domestic Violence Hotline: 800-799-SAFE
Wounded Soldier & Family Hotline: 800-984-8523
National Runaway Hotline: 800-786-2929
Adult Protective Services Hotline: 888-832-3858

COMMUNITY SERVICES IN HOPWELL, VA

Alcoholics Anonymous: 804-452-1959
Al-Anon/Alateen: 804-861-2620
AL-A-MO Recovery Center: 804-733-9898
District 19 CSB (Petersburg): 804-862-8002
CARES: 804-861-0849
The James House: 804-458-2704
Poplar Springs Hospital: 804-733-6874
Shriner's Hospital: 800-237-5055
Petersburg Health Care Alliance: 804-863-1652
Hopewell Social Services: 804-541-2330
Victim Witness Assistance Program: 804-541-2352
Public Health Department Hopewell: 804-458-1297
YWCA: 804-796-3066

Hopewell Crisis Lines:

Emergency: 911
Hopewell: 804-862-8000
The James House (24-hr hotline): 804-458-2840
Helping Hand Hotline: 804-796-2100
Virginia Family Violence Hotline: 800-838-8238

Financial Counseling and Assistance Programs:

CCHASM: 804-796-2749
Consumer Credit Counseling: 804-520-8744
Cooperative Extension Services: 804-733-2686
Hopewell Social Services: 804-541-2330
Victim Witness: 804-541-2352

Taxi Services:

AAA Taxicab Company: 804-862-8111
Richmond Flyer Taxi: 804-914-5544

WEB RESOURCES

Kenner Army Health Clinic: <http://mufs.narmc.ameddc.army.mil/kenner>
Tricare: www.tricareonline.com and www.mytricare.com
Military One Source: www.militaryonesource.com
John Randolph Medical Center: www.johnrandolphmed.com
National Resource Directory: www.nationalresourcedirectory.org
Fort Lee ACS: www.leemwr.com/Comm/ACS/com_acs_scs.htm
49th Quartermaster Group: www.49thgrp.army.mil

www.TeamTrainingOnline.org
866-553-5808 info@TeamTrainingOnline.org

*Training material adapted from the National Center for PTSD and National Child Traumatic Stress Network's Psychological First Aid (2008) and Skills for Psychological Recovery (2007) Field Guides

Defense Centers of Excellence
for Psychological Health
and Traumatic Brain Injury



C4. Orientation Session – Resources at Fort Lee (Comparison Group)



Troop Education for Army Morale



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Social Work Services: 804-734-9152
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Shriner's Hospital: 800-237-5055
Petersburg Health Care Alliance: 804-863-1652
Hopewell Social Services: 804-541-2330
Victim Witness Assistance Program: 804-541-2352
Public Health Department Hopewell: 804-458-1297
YWCA: 804-796-3066

Hopewell Crisis Lines:

Emergency: 911
Hopewell: 804-862-8000
The James House (24-hr hotline): 804-458-2840
Helping Hand Hotline: 804-796-2100
Virginia Family Violence Hotline: 800-838-8238

Financial Counseling and Assistance Programs:

CCHASM: 804-796-2749
Consumer Credit Counseling: 804-520-8744
Cooperative Extension Services: 804-733-2686
Hopewell Social Services: 804-541-2330
Victim Witness: 804-541-2352

Taxi Services:

AAA Taxicab Company: 804-862-8111
Richmond Flyer Taxi: 804-914-5544

WEB RESOURCES

Kenner Army Health Clinic: <http://mtns.narmc.ameddc.army.mil/kenner>
Tricare: www.tricareonline.com and www.mytricare.com
Military One Source: www.militaryonesource.com
John Randolph Medical Center: www.johnrandolphmed.com
National Resource Directory: www.nationalresourcedirectory.org
Fort Lee ACS: www.leemwr.com/Comm/ACS/com_acs_acs.htm
49th Quartermaster Group: www.49thgrp.army.mil



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C5. Orientation Session – Wallet Card

NATIONAL HEALTHCARE RESOURCES

National Alcohol & Drug Helpline	800-662-HELP
National Suicide Prevention Lifeline	800-273-TALK
National Domestic Violence Hotline	800-795-SAFE
Wounded Soldier & Family Hotline	800-984-8523
Helping Hand Hotline	804-798-2100
TRICARE	877-874-2273
Military One Source	800-342-9647



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FORT LEE LOCAL HEALTHCARE RESOURCES

Kenner Army Health Clinic	804-734-9000
<i>Appointment Line</i>	804-615-4584
<i>Behavioral Health</i>	804-734-9623
<i>Social Work Services</i>	804-734-9152
<i>Substance Abuse Counseling</i>	804-734-9601
Army Community Services	804-734-6388
Soldier & Family Assistance Center	804-734-6445
Virginia South Psych. & Family Services	804-341-3913

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C6. Orientation Session – Childcare Information



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Childcare Information

Childcare services will be provided by Child, Youth & School Services during the TEAM workshops for spouses. The Child, Youth & School Service's Central Registration Office (CYS/CRO) is a one-stop registration point for the Child Development Center and Family Child Care programs. To access the childcare services, you must register your children with the CYS/CRO no later than one week prior to the first spouse workshop.

How do I sign up for childcare?

- Register your children with the CYS/CRO. The CYS/CRO will ensure that you are signed up for the childcare services that are available during the spouse workshops.
- The registration will take approximately 30 minutes. You can walk-in anytime during CYS/CRO business hours: Monday through Friday, 7:30 a.m.-1:00 p.m. and 2:00-4:30 p.m.
- CYS/CRO contact: Building 10612, Phone: (804) 765-3852, (DSN) 539-3852

What do I need to bring with me to register for childcare service?

- A complete registration packet (available at www.leemwr.com/CYS/cys_cys_forms.htm)
- Up-to-date shot record
- Contact information for three adult emergency designees who live within 30 minutes of Ft. Lee
- Records showing proof of child's age (birth certificate / ID card) and parent/guardian's legal custody
- Record of physical exam. You have 30 days to provide proof of physical exam (exam records are good for one year). If your child needs an exam, it is recommended that you make an appointment as soon as possible because appointment times fill fast.
- The latest Leave and Earnings Statement (LES) is NOT necessary to sign up for childcare during the TEAM workshops for spouses. However, you may need to bring the latest LES if you are registering for other programs at the same time.



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C7. Orientation Session – Five Principles of Psychological First Aid



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Five Principles of Psychological First Aid

Sometimes people are faced with challenging life events. Such events can lead to a variety of responses including stress. Psychological First Aid is a flexible set of skills that can be used to improve coping and well-being, and help you work through and overcome difficult events.

The five principles of Psychological First Aid are:

1. Safety: Safety is about protecting yourself from harm. To be safe you must be aware of the circumstances and take action (or not take action) to make sure you are okay. Safety can mean taking care of yourself when you are actually in danger and when you feel unsafe but are not really in danger. When you were downrange, safety might have meant looking out for IEDs and protecting yourself from rocket fire. However, you might feel unsafe after you return home even if you are no longer in danger – but you might feel as stressed as you did downrange but without good cause. For example, this might occur in crowded places, congested traffic, near loud noises or when people make you angry. At these times, you could react to your own emotions and act in an unsafe manner such as driving too fast, drinking too much or responding violently when provoked.

As a Soldier, you have been trained to protect yourself when in danger. It is also important to learn to recognize when you feel threatened (or unsafe) when you are not really in danger. Here are some things you can do if this happens to you:

- Take a moment to think about your feelings. Are they appropriate to the current situation?
- Modify your reactions to fit the situation.
- Know the triggers that signal threat for you and your typical reactions.
- If possible, remove yourself from a situation where you feel threatened.
- Get feedback from someone you trust. Talk about when and why you feel the way you do. This can serve as a “reality check.”
- Use calming techniques [see next section] can help you relax, feel more comfortable and control your reactions.

2. Calming: Sometimes people feel keyed up, nervous or agitated – we all feel this way at times. It is important to recognize these feelings and if they are interfering with your sleep, decision-making and everyday activities – both at home and at work. Learning to recognize these feelings is the first step in doing something about them so they do not get in the way of your everyday life. Below are some things you can do to help you be more aware of your feelings and to calm down and relax if things feel out of control:

- Stop and take a deep breath. Be conscious of your breathing; breathe more slowly and deeply.
- Take time for yourself; take a break from busy activities.
- Do something you like to do or listen to music you enjoy or watch a movie to get your mind off things.
- Take a 10-minute walk, exercise or stretch to reduce tension and relax your body and mind.

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You can also help others to relax. Some good ways to help others are:

- Encourage the person to talk and share what is going on. However, do not force them to talk if they are not ready.
- Just being with a friend in trouble can be helpful.
- Suggest an activity that you know they like to do.
- Be friendly and compassionate even if people are being difficult or seem angry. Recognize that the anger is not about you.

3. **Connectedness:** Giving and receiving support is one of the best ways to deal with stress. When you give support to others, you will also feel the connection to them.

- Seek out people you feel comfortable with.
- Spend time with people. You do not have to talk about problems if you do not want to, just being with someone else can be helpful and make you feel not so alone.
- Do something you enjoy with someone else, for example, go for a walk, work out, play sports, read, watch a movie, take pictures of something you like, take your dog for a walk or throw a frisbee, draw or paint, dance, sing, play an instrument or volunteer somewhere.
- Touch base with your children and other relatives. Do activities with them or just talk on the phone.

4. **Self-Efficacy** (the “I can do it!” attitude): Self-efficacy might sound complicated but it is simply believing in your own abilities. Here are some ways to build this attitude into yourself and others:

- Focus on your strengths (not what is wrong in your life).
- Look for ways to help yourself.
- Break large tasks down into small tasks that you can and do achieve. This sets a pattern of feeling successful about your abilities.
- When you need it, seek out help that will get you to your goal.
- You do not always have to “go it alone” to be successful.
- Find out the types and locations of services that can help you.

5. **Hope/Optimism:** Hope is the idea that a positive future can happen to you. An optimistic outlook is recognizing the steps necessary to reach your goals and being positive about your ability to reach your goals. Many of the ideas presented above will help build optimism over time, for example, being safe, calming yourself, connecting with others and the belief that “I can do it!” Here are some specific tips for building hope/optimism:

- Look for and find meaning in your experiences.
- Look for and find the benefits that you have in your life and in the lives of others.
- Use systems of support that you find positive, including faith and religious practice.
- Recognize what is good in your own life and the lives of others (do not focus on the negative).

C8. Orientation Session – Returning Home for Soldiers



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Returning Home for Soldiers

Homecoming is a process that takes time. While coming home represents a return to safety, the routines of home are quite different from a regimented life in a war zone. Be patient readjustment takes time and this is different for each person. Recognize that many things do not return to what they used to be like. Remember that your family is also going through a readjustment.

Observe

- Celebrate in a way that is safe and feels comfortable and right for you.
- Talking about war experiences is a personal matter. You may or may not wish to share experiences with others.
- Help others understand that you may need time for yourself. Let them know that you are not ignoring or slighting them but just sometimes need time to be alone.
- Rest. You and others may be keyed up and sleeping poorly.
- Be flexible and have reasonable expectations of yourself and others. Do not try to do too much too soon.

Exercise Caution

- *When driving.* Driving can be hazardous when you have not operated a conventional motor vehicle in a long time. What was dangerous down range may not be dangerous here. Be careful when driving with someone else in the car – it is an easy way to get distracted.
- *When drinking alcoholic beverages.* Recognize your limits and help others to recognize theirs. Excessive use of alcohol can be a warning sign of distress. It can increase the risk of accidents and decrease the opportunity to communicate with other people.

Going Back To Duties at the Unit

- Returning to garrison life can be stressful. You may not feel that the work is as important as your work in the war. Remember that every job contributes to the overall mission. You can use this time to re-adjust to new demands and know that others are trying to do the same.



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C9. Intervention Session 1 – Common Reactions When Dealing with Difficult Events



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COMMON REACTIONS WHEN DEALING WITH DIFFICULT EVENTS

Anger

- Feeling irritable or "on edge"
- Lacking patience
- Intense emotions of hate, fear, or guilt
- Becoming violent

WHAT HELPS:

- Walk away, cool off, talk to a friend, distract yourself with positive activities, etc
- Remind yourself that being angry may harm important relationships
- If you become violent, get immediate help

Withdrawal

- Feeling distant from others
- Loss of interest in activities and hobbies
- Low work output or trouble making decisions
- Wanting to be alone more than usual

WHAT HELPS:

- Family and friends can be a source of support
- Continue to participate in activities you enjoy
- Rely on loved ones for help and ask for it

Avoidance

- Avoiding talking, thinking, and having feelings about the event
- Avoiding reminders of the event

WHAT HELPS:

- Remain active
- Go places and do things with others

Tension/Stress

- Feeling jumpy or nervous
- Worrying about the future
- Poor concentration or attention
- Rapid heartbeat and sweating

WHAT HELPS:

- Do something relaxing or just for fun
- Use relaxation methods such as deep breathing or exercise
- Get proper sleep

Unsafe Behaviors

- Drugs
- Drunk driving
- Sexual promiscuity

WHAT HELPS:

- Call a cab or a friend for a ride home
- Practice safe sex
- Identify positive activities to replace risky behaviors

Sleep Difficulties

- Trouble falling asleep
- Problems staying asleep
- Nightmares

WHAT HELPS:

- Go to bed at the same time every day
- Increase daytime exercise but relax before bedtime
- Don't drink caffeine in the evening

"Frankly, it's a little weird to me that people are making a big deal about it."

Like lots of soldiers I needed a little help, and I got a little help."

-GEN. Carter Ham, United States Army, talks about the difficulties of readjusting to life after a deployment.

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C10. Intervention Session 1 – Alcohol, Medication, and Drug Use after Difficult Events



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ALCOHOL, MEDICATION, AND DRUG USE AFTER DIFFICULT EVENTS

Increased use of alcohol, prescription medications and other drugs is common after difficult events. Some people use them to escape bad feelings or physical problems. But in the long run, they can actually make things worse. Over time, alcohol and drugs can interrupt natural sleep patterns, cause health problems, interfere with relationships, and increase risk for dependence.

Managing Alcohol, Medication and Drug Use

- Pay attention to any changes in your use
- Follow proper directions for prescription and over-the-counter medications
- Eat well, exercise, get enough sleep
- Family and friends can be important sources of support
- If you are having greater difficulty controlling alcohol and/or drug use since a difficult event, seek help
- If you can't get your drinking or drug use under control you might want to consult a healthcare professional or chaplain

If You Have Had an Alcohol, Medication, or Drug Problem in the Past

A difficult event can cause strong urges to drink or use drugs – especially in people who have had problems with alcohol or drug use in the past. An awareness of the risk of relapse can help people stay in recovery or seek support.

- Turn to what has helped in the past.
- Attend (or increase attendance) at substance abuse support groups
- If you are receiving supportive counseling, talk to your counselor about your past alcohol or drug use
- If you have recently moved, talk to others about finding local alcohol or drug recovery groups or ask them to help organize a new support group
- Talk with family and friends about supporting your efforts to avoid the use of alcohol and/or drugs
- If you have a 12-Step sponsor or substance abuse counselor, talk to him or her about your situation
- Increase your use of other supports that have helped you avoid relapse in the past



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C11. Intervention Session 2 – Calming Techniques



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CALMING TECHNIQUES

Muscle Relaxation Technique

Hands:

Look at your hands. Your hands are relaxed when you rest them on your lap in a slightly open position. Continue to relax for a few minutes and notice how your hands and arms feel in this position.

Feet:

Look at your feet. Your feet are relaxed when both heels are resting on the floor. Your feet are not relaxed if they are crossed. Continue to relax your feet, notice the feelings in your legs and feet.

Body:

Feel how your body is positioned in your chair. Your body is relaxed when your chest and hips are straight in the chair with no movement. It is not relaxed if your torso is crooked. Now take a few moments to notice the sensations as you relax your body.

Shoulders:

Shake out your shoulders. Your shoulders are relaxed when your chest and hips are straight in the chair with no movement. If your shoulders are crooked, your body is not relaxed. Now take a few moments to notice the sensations as you relax your shoulders.

Head:

Move your head from side to side. Your head is relaxed when it is in alignment and facing straight ahead. If you have a chair with a high back, your head can rest on the cushioned back of the chair. It is not relaxed if it is crooked. Take a few moments to notice the sensations as you relax your head.

Mouth:

Move your mouth. Your mouth is relaxed when your teeth are parted and your lips are open in the center. Your mouth is not relaxed if your lips are closed, if you smile, or lick your lips. Now take a few moments to notice the sensations as you relax your mouth.

Throat:

Feel yourself swallow. Your throat is relaxed when it is smooth and quiet. Your throat is not relaxed if there is a lot of swallowing or muscle twitching. Now take a moment to notice the sensations as you relax your throat.

Quiet:

Take a moment and listen. You are quiet when you are not making any noise, such as talking or loud sighs, and when you are focused on your own internal sensations. Focus on quiet for the next few moments. Let any distracting noises fade into the background as you focus on your breathing.

Eyes:

Notice your eyes. Your eyes are relaxed when the lids are closed and smooth. Your eyes are not relaxed when they are tightly shut, or if there is eye movement beneath the lids. Please relax your eyes. Feel the sensations as you allow your eyes to relax.



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Breathing Technique

1. Inhale slowly (one-thousand one, one-thousand two, one-thousand three) through your nose and comfortably fill your lungs all the way down to your belly.
2. Silently and gently, say to yourself, "My body is filled with calmness." Exhale slowly (one-thousand one, one-thousand two, one-thousand three) through your mouth and comfortably empty your lungs all the way down to your abdomen.
3. Silently and gently, say to yourself, "My body is releasing the tension."
4. Repeat five times slowly and comfortably.
5. Do this as many times a day as needed.

Imagery Technique

The things we think and the images that we visualize in our heads contribute to our level of relaxation. If we think about troubling events or have troubling images in mind, we can become tense and upset. Similarly, if we think peaceful, pleasant thoughts and visualize pleasant images, it will help us to become calm.

In this technique, the goal is to visualize yourself in a peaceful setting.

1. Lie on your back with your eyes closed.
2. Imagine yourself in a favorite, peaceful place. The place may be on a sunny beach with the ocean breezes caressing you, swinging in a hammock in the mountains or in your own backyard. Any place that you find peaceful and relaxing is OK.
3. Imagine you are there. See and feel your surroundings, hear the peaceful sounds, smell the flowers or the barbecue, feel the warmth of the sun and any other sensations that you find. Relax and enjoy it.
4. You can return to this place any night you need to. As you use this place more and more you will find it easier to fall asleep as this imagery becomes a sleep conditioner.
5. Some patients find it useful to visualize something boring. This may be a particularly boring teacher or lecturer, co-worker or friend.

If you practice the calming techniques on a regular basis, regardless of whether you feel anxious or tense, you will be better able to use them when you really need them. Think of the process of learning calming skills as you would any other skill (like riding a bike) — it may take time to master, but once learned it is easy to apply.

C12. Intervention Session 2 – Connecting with Others



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CONNECTING WITH OTHERS

Most people deal with problems better when they feel connected to others who care about them. The following information may help you improve the way you connect with people you care about.

Reasons Why People May Avoid Social Support

- Not knowing what they need
- Feeling embarrassed or "weak"
- Feeling they will lose control
- Doubting it will help
- Doubting that others will understand
- Tried to get help in the past but felt that it was a waste of time
- Wanting to avoid thinking or having feelings about a difficult event
- Not wanting to burden others
- Feeling that others will be disappointed or judgmental
- Not knowing where to get help

Good Things to Do When Giving Support

- Show interest, attention, and care
- Find an uninterrupted time and place to talk
- Talk about expectable reactions to difficult events and healthy coping
- Believe that the person is capable of recovery
- Acknowledge that stress reactions can take time to resolve
- Help brainstorm positive ways to deal with their reactions
- Show respect for individuals' reactions and ways of coping
- Be free of expectations or judgments
- Offer to talk or spend time together as many times as is needed

Things That Interfere with Giving Support

- Rushing to tell someone that he/she will be okay or that they should just "get over it"
- Discussing your own personal experiences without listening to the other person's story
- Acting like someone is weak or exaggerating because he or she isn't coping as well
- Stopping the person from talking about what is bothering them
- Telling them they were lucky it wasn't worse

When Your Support is Not Enough

- Encourage them to get involved in a support group with others who have similar experiences
- Enlist help from others in your social circle so that you all take part in supporting the person
- Encourage them to talk with a counselor, clergy, or medical professional, and offer to accompany them
- Explain that avoidance and withdrawal are likely to increase distress



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C13. Intervention Session 3 – Problem Solving



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PROBLEM SOLVING

When difficult events happen, people can feel overwhelmed. This sometimes makes it hard to figure out the best thing to do. The steps below are a common sense way of focusing on one problem at a time. They may help you carefully choose a plan of action to solve your problems.

Step 1: Define the Problem:

1. Define the problem carefully. This is important because if the problem is described in a clear and concrete way, it will be easier to identify practical steps toward a solution.
2. Often, problems that seem big can be broken down into smaller ones that are easier to solve.
3. Focus on one problem at a time.
4. Spell out the problem on a piece of paper.

Step 2: Make a List of Possible Solutions:

1. Write out a list of possible solutions on a piece of paper. The list will help you see that you have options for how you can cut the problem down to size and make the situation better. It will help you see that you have more control than you might think. "Brainstorm" as many possible solutions as you can and be very specific when you write them on your list. The goal is to come up with as many ideas as you can and not worry about how effective they might be. Write down any ideas you have, including ones that might seem obvious or silly.
2. Types of solutions you might want to include:
 - Ways of calming yourself
 - Taking action on parts of the problem that are controllable
 - Using techniques that have worked for you in the past
 - Learning new skills to deal with other difficult situations
 - Getting help/support or suggestions
3. End this phase of problem solving when you have listed 5-10 ideas or when you are "running dry" of ideas.

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Step 3: Choose the Best Solutions:

1. Circle the solutions that seem the most practical and workable. These should be solutions that you are willing to do and ones you are able to put into action most easily.
2. Now, which approach seems the most realistic to accomplish for now? Do you have the resources or can you get the help you might need to get started? Do you have enough time to follow through with the plan?
3. Start with the approach that will result in the most immediate impact. Then focus on solving more long term problems.

Step 4: Specify a Plan of Action and Act:

1. Specify the steps you will take to put your plan into action. Commit to taking those steps within a reasonable time. Don't put off your plan, start now!
2. What are indicators that things are working?
3. What resources will you need in terms of people, money and facilities?
4. How much time will you need to implement the solution? Write a schedule that includes the start and stop times, and when you expect to see certain indicators of success. Try not to be impatient, things often take time to turn around and begin working.
5. Write down the answers to the above questions. Consider this as your action plan and follow it! Be flexible. If something isn't working, review your list and try something else. As things change you may want to make adjustments to your plan.

C14. Intervention Session 3 – Buddy Care: Helping Your Buddy Solve Problems



Troop Education for Army Morale



BUDDY CARE: HELPING YOUR BUDDY SOLVE PROBLEMS

It can be difficult to solve problems alone when one is facing a difficult situation. If your buddy is having a hard time, you may be able to help him/her increase a sense of hope, dignity, empowerment and control. Helping your buddy solve problems can be done in many ways including providing resources, helping him/her to address identified needs and helping to set achievable goals. Letting your buddy know you care about them is an important part of helping. The following four steps can guide you in helping your buddy:

Step 1: Identify the most immediate needs: If a buddy has several current concerns, it's helpful to focus on them one at a time. First, work on those issues that need immediate attention. For some, there will be immediate needs such as rest and respite. Other needs may not be solved so quickly, such as obtaining health care after deployment. You can help your buddy take concrete steps to address the problem such as setting an appointment for health care services.

Step 2: Help clarify the need: Help your buddy identify the problem. If the problem is clear and well understood, it will be easier to help identify and implement practical steps to address it.

Step 3: Discuss an action plan: Discuss with your buddy what can be done to address their need or concern. Your buddy may say what he/she would like to be done, or you can offer a suggestion. Keep your buddy actively involved in "brainstorming" solutions. If you know what services are available ahead of time (e.g., financial assistance, medical or mental health care, or spiritual care services), then you can aid in obtaining those services. Discuss what can be expected in realistic terms.

Step 4: Act to address the need: Help your buddy to take action. For example, help him/her set an appointment or complete paperwork.

Step 5: Follow-up: Tell your buddy you will be giving them a call in a few days to see how things are going.

Be flexible – If something isn't working help come up with other ideas or suggestions. Keep trying and let your buddy know you won't give up on him or her.



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C15. Intervention Session 4 – Helpful Coping Strategies



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Helpful Coping Strategies

Below are useful strategies for managing difficult emotions. You have probably used some of these at various times in your life, although you may not have thought about them as strategies. Often, people forget to use coping strategies when they need them the most. Experiment with the suggestions below - some strategies may work better for you than others.

Sleep/Nutrition/Exercise: One way to feel better is to take better care of yourself. Sleep, diet and exercise are some of the first areas to suffer when people are under stress. Try eating better and getting regular exercise. If sleep is a problem, have good sleep routines: go to sleep at the same time every day, limit daytime naps to 15 minutes, don't nap after 4 pm, no caffeine in the evening, and remember that alcohol reduces your quality of sleep.

Talk to Someone: Sometimes it can be useful to talk through upsetting thoughts and feelings with a trusted friend. Alternatively, you may decide to talk with a friend about other topics, in an effort to get your mind off distressing thoughts and feelings for a time.

Spirituality: If you have a spiritual or religious practice, drawing on these beliefs, traditions, and practices may prove useful in times of stress.

Schedule Pleasant Activities: Increasing the number of positive activities that you engage in will help you feel better. Identify activities that you find enjoyable and schedule them into your day. Although being active and engaged is often the last thing you want to do if you are feeling depressed, it is actually a very effective way to combat a depressed mood.

Breathing for Relaxation: Breathing exercises are a quick way to reduce anxiety and tension. Practice often when you are not anxious. Then, when you are anxious, breathing can reduce your anxiety to a manageable level so you can more easily cope with other problems.

Challenge Your Thinking: Thoughts are related to feelings and behaviors. Challenge your thinking to find out whether inaccurate and unrealistic thought processes are contributing to feelings of distress. If so, develop an alternative thought and action plans. For example, the thought, "I just can't cope with problem X" may be changed to "I can cope with problem X if I work on it one step at a time, and I will work on one step now."

Positive Coping Statements: Sometimes saying things in a different way can help you feel better. When facing a difficult situation, tell yourself positive things instead of negative, hopeless things. Remind yourself that you can get through the situation and that you are learning new skills for dealing with difficult situations. Remember that feelings pass with time. No feeling is final.

Distraction: Distraction can be useful for regulating your emotions in situations in which it is not desirable, appropriate, or possible to fully experience or express your emotions (such as when you are in a business meeting, a class, etc.). Although distraction is a useful coping strategy, it should only be used in moderation. Be sure that you are not relying on distraction to avoid your painful emotions all of the time. Distraction might include a scheduled pleasant event or something more unplanned such as calling someone on the phone to chat, going for a walk, going shopping, etc.



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*Training material adapted from the National Center for PTSD and National Child Traumatic Stress Network's Psychological First Aid (2008) and Skills for Psychological Recovery (2007) Field Guides

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C16. Intervention Session 4 – TEAM Take Home Points



Troop Education for Army Morale



TEAM Take Home Points

When Terrible Things Happen: What Positive and Negative Reactions You May Experience

- *Common Negative Reactions:* Irritability, anger, difficulty sleeping and concentrating, physical reactions, emotional detachment, and recurrent distressing thoughts or images.
- *Common Positive Reactions:* Increased appreciation for and commitment to family and friends, positive change in worldview, changes in priorities, unexpected coping strengths.
- *What Helps:* Maintain a normal schedule, take breaks, focus on the practical and positive, get rest and healthy meals, exercise, engage in positive activities, spend time with others.
- *What Doesn't Help:* Using alcohol/drugs, not taking care of yourself, working too much.

Overcoming Difficult Events: Common Reactions and Examples of Things to Do and Say

- *Feeling Overwhelmed?* List concerns and identify top priorities, break tasks down into manageable steps, seek available help, rely on your family, friends and community.
- *Excessive Anger?* Walk away from stressful situations, cool down, talk to a friend, get physical exercise, distract yourself with positive activities, problem-solve the situation.
- *Sleep Difficulties?* Keep a consistent sleep schedule, exercise in the daytime, relax before bedtime, reduce alcohol consumption, no caffeine in the evening, no naps after 4 pm.
- *Shifts in Interpersonal Relationships?* Tolerate different ways of working through problems, ask family and friends how they are doing, say to family or friends, "We're crabby with each other and that is completely normal, given what we've been through."

Alcohol, Medication, and Drug Use after Difficult Events

- Pay attention to any change in your use of alcohol and/or drugs.
- If you find that you have difficulty controlling alcohol or substance use, seek support.
- If you have had an alcohol, medication, or drug problem in the past, talk to your family, friends, your 12-step sponsor, or counselor about your situation.

Calming Techniques

- When tense, anxious or over-aroused: Take a normal breath and exhale very slowly while silently repeating a cue word that you find calming (e.g., say "relax" or "calm"). Pause and count to four before taking the next breath. Repeat the entire sequence 10 to 15 times.
- Increase activities that promote positive emotions.
- Alcohol and drugs are not helpful for calming and interfere with normal sleep.

Connecting with Others: Seeking Social Support

- *Explore Support Options:* Spouses, trusted family members, close friends, counselors, clergy, co-workers, and support groups are potential sources of good social support.
- *Don't:* Wait until you are stressed out to seek help, assume others won't want to help, or keep quiet because you are worried about being a burden or upsetting others.
- *Do:* Decide what to discuss and when to talk, state the main thing you need and how others can help, talk about painful thoughts/feelings when you are ready, thank supporter.

(Continues on back side)

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Connecting with Others: Giving Social Support

- *Why People Avoid Seeking Support:* Doubt that others will understand or help, wanting to avoid thinking about problem, feeling embarrassed or weak, not sure where to get help.
- *Don't:* Act like the person is weak or exaggerating, stop the person from talking about what is bothering them, rush to tell someone they will be okay, give advice without listening.
- *Do:* Show interest and care, respect others' ways of coping, help brainstorm positive ways to deal with problems, offer to talk or get together as much as is needed.

Problem Solving

- *Define the Problem:* Focus on one problem at a time, break big problems down to small parts, carefully and clearly define the problem, write definition of problem on paper.
- *List Possible Solutions:* Write down at least 10 practical, useful and specific solutions.
- *Choose the Best Solution:* Circle solutions that seem the most reasonable and helpful, solutions that you would be willing to do and that you would like to put into action.
- *Specify a Plan of Action and Act:* Specify steps you will take to put your plan into action, commit to taking those steps within a reasonable time, take action and follow your plan.

Helpful Thinking

- Appraisals are the thoughts and beliefs that run through a person's head when they consider a situation. Emotions are the result of appraisals. Distorted, inaccurate, or pessimistic appraisals may lead to negative emotions.
- Increase awareness of your appraisals that lead to negative emotions (e.g., the appraisal, "The world is a dangerous place" may result in feelings of fear, mistrust, and anxiety).
- Replacing distorted or pessimistic appraisals with ones that are realistic and optimistic will lead to different, more positive emotions (e.g., the new appraisal, "The world is not always dangerous" is more likely to result in feelings of hope, trust, peace and calm).

Other Helpful Coping Strategies

- *Talk to Someone:* Sometimes it can be useful to talk through upsetting thoughts and feelings with a trusted friend. Alternately, you may decide to talk with a friend about other topics, in an effort to get your mind off distressing thoughts and feelings for a time.
- *Spirituality:* If you have a spiritual or religious practice, drawing on your beliefs, traditions and practices during difficult times may be of great benefit for you.
- *Schedule Pleasant Activities:* Although you may not feel like being active when your mood is low, increasing the number of positive activities you do is an effective way to combat a depressed mood. Identify things you enjoy and schedule them into your day.

C17. Intervention Session 4 – Following Medical Recommendations for Health



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Following Medical Recommendations for Health

While we often look to doctors and the healthcare system to take care of us, we have a very important role in maintaining our health. Doctors are health experts who work with us to provide a plan for meeting our healthcare needs (e.g., starting a diet to lower cholesterol, having a cardiac stress test or taking medicine). It is up to us to follow through with the plan and to give the doctor feedback about whether the plan works, does not work or needs to be altered. Sometimes we do not follow through with our part in the plan. How many of us have stopped taking a medicine without consulting the doctor because we felt better? It may not have occurred to us that being on the medicine is the reason we feel better - a sign that the medicine is working.

The following tips can help you build a good and trusting relationship with your doctor and the system of care that supports your health.

Prepare for Your Visit

- Write a list of your questions and symptoms in advance.
- Bring this list along with a pen or pencil and pad to take notes.
- Provide your doctor with a list of all your medications, how often you take them and their strength (including all non-prescribed medicines such as supplements).
- Bring along a family member or friend if language or hearing is a problem.

Communicate Openly with Your Doctor

- Express your needs and your concerns over side effects and sensitive topics (e.g., weight gain and sexual functioning are concerns that your provider can discuss with you).
- Ask for clarification. If you do not understand something, don't hesitate to ask again or ask your doctor to write it down.

Request a Treatment Suitable for Your Lifestyle

- Think of anything that might present a barrier to following what your doctor tells you to do and discuss it with your doctor and others whom you trust.
- If you have trouble swallowing a pill, ask if the medicine comes in a liquid form.
- If you tend to be forgetful or feel uncomfortable taking a medicine at work, ask if the medicine comes in a time-release capsule or if you can take it less often.
- Utilize your doctor's resources (e.g., ask if your doctor has a nurse practitioner or case manager who may be available by telephone).

Reinforce Good Health Habits for Your Entire Family

- Use your own health behavior as an example for your children. Explain the importance of washing hands, covering the mouth while coughing, eating foods to maintain healthy weight and nutrition, and most of all, the importance of building these behaviors into your daily routine.



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C18. Intervention Session 4 – The Bottom Line



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The Bottom Line

Remember the following tips to help yourself and others when confronting stress or difficult events:

- Be hopeful, positive, and optimistic—look for the good in people and situations
- Find support in a variety of sources—it is okay to ask for practical and emotional support
- Break big problems down into small manageable parts—get help if you need it
- Know your limits—act upon things that you can control, not on things you can not control
- H.A.L.T. when needed—do not let yourself get too Hungry, Angry, Lonely or Tired



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Appendix D – Intervention Website

- D1. Website Screen Shots**
- D2. Handout – Acute Stress Disorder and Post Traumatic Stress Disorder**
- D3. Handout – Leadership During Mortuary Affairs Operations**
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- D13. Handout – Helpful Thinking**

D1. Website Screen Shots

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Welcome to the TEAM site

TEAM Mission: *To assist in the re-integration of Mortuary Affairs Soldiers and their families after deployment*



TEAM is an educational program designed to help U.S. Army Mortuary Affairs Soldiers and their spouses and families after deployment. TEAM is designed to build personal, family and group skills to deal with difficult events. The TEAM program is based on the concept of Psychological First Aid, a set of recommended principles developed by the National Center for PTSD and others for assisting people after disasters and other traumatic events. The principles of PFA have been adapted to make them applicable to Mortuary Affairs Soldiers and their spouses. The TEAM program has much to offer Soldiers and their spouses including workshops, handouts, a toll-free phone line, email services and this website. We hope you find the TEAM program beneficial and we appreciate your participation.

If you or someone you know needs help, please refer to the list of health and support organizations on the handout [Resources at Fort Lee and the Surrounding Area](#). If there is an immediate risk of harm to self or others, call 911.

TEAM Toll-Free Information Line: 866-553-5808
TEAM Email Address: Info@TeamTrainingOnline.org

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[TEAM Handouts](#)**About TEAM: Program Description**

TEAM (Troop Education for Army Morale) is an educational program designed to help Mortuary Affairs Soldiers and their families after deployment. Its purpose is to build personal, family and group skills to deal with difficult events. The TEAM program is based on the concept of Psychological First Aid (PFA). PFA is a set of recommended principles developed by the National Center for PTSD (and others) for assisting people after disasters and other traumatic events. The PFA principles have been adapted to make them applicable to Soldiers and their spouses in dealing with adjustments associated with the return from a deployment. PFA emphasizes five concepts:

1. **Safety** - Being aware of and taking action to protect yourself and others
2. **Calming** - Things to do when you feel keyed up, nervous or agitated
3. **Connectedness** - Receiving and giving support; connecting with individuals and helpful community resources
4. **Self-efficacy** - A belief in one's own capacity to achieve certain goals and a belief that group goals are attainable (an "I can do it!" attitude)
5. **Hope/optimism** - The belief and expectation that a positive future is possible

The education and training component of TEAM combines a series of three workshops, one per month at 30, 60 and 90 days post deployment and a booster workshop at six months, which will review all of the covered material. To augment this training, there is a series of web site resources, an email service and a toll-free telephone information line staffed by TEAM members to assist you with questions. The TEAM program will be offered to the spouses of Soldiers who are in TEAM. Spouses will have the opportunity to attend their own workshops and have access to the on-line materials, email service and the toll-free telephone information line.

Since the TEAM program is also a research study, Soldiers who volunteer will be asked to fill out brief surveys about the types of personal and health challenges they face upon return from deployment and about the helpfulness of the TEAM program in dealing with those challenges. Spouses will not receive surveys.

The TEAM program is not mandatory. Participation in TEAM is completely voluntary and you may withdraw from participation at any time. Your Command will arrange for you to be available for the training sessions.

We believe the TEAM program has much to offer Mortuary Affairs Soldiers returning from deployment and their families. We hope you find it beneficial and we appreciate your participation.

James E. McCarroll, Ph.D.
TEAM Program Leader

Carol S. Fullerton, Ph.D.
TEAM Program Director

TEAM Toll-Free Information Line: 866-553-5808
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Workshop 1

► **What is TEAM?**

What is TEAM?

TEAM (Troop Education for Army Morale) is an educational program to help soldiers and their spouses and families after deployment. TEAM is voluntary and consists of 4 workshops in which we interact separately with Soldiers and their spouses to talk about things that are important to you. Its purpose is to build personal, family, and group skills to deal with difficult events.

What it is not:

TEAM is not mental health treatment
TEAM is not therapy
TEAM is not part of your medical care
TEAM is not part of your medical or personnel records

Additional Material:

[Workshop 1 Slides](#)

► **What did I sign up for?**

► **In addition to TEAM, what are the resources available for me or for others in this area?**

► **What is Psychological First Aid?**

► **What are some common responses to difficult events?**

► **What if I have trouble sleeping?**

► **Should I be concerned about my drinking?**

► **Am I too angry?**

► **What does safety mean?**

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- ▶ [What is Psychological First Aid?](#)

What is Psychological First Aid?

Psychological First Aid is a set of skills to use when faced with challenging emotional or mental events. PFA can be helpful for working through your own concerns and for helping others.

The five areas of Psychological First Aid are:

1. **Safety** - Being aware of and taking action to protect yourself and others
2. **Calming** - Things to do when you feel keyed up, nervous or agitated
3. **Connectedness** - Receiving and giving support; connecting with individuals and helpful community resources
4. **Self-efficacy** - A belief in one's own capacity to achieve certain goals and a belief that group goals are attainable (an "I can do it!" attitude)
5. **Hope/optimism** - The belief and expectation that a positive future is possible

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Workshop 2

► Why is calming important?

Why is calming important?

Calming can help you relax, feel more comfortable and control your reactions. Feeling hyper can interfere with sleep, decision-making, doing everyday things, and can lead to other reactions including violence, alcohol abuse, and health problems.

What are some good ways of calming myself?

Be conscious of your breathing; breathe more slowly and deeply
Take time for yourself; take a break from busy activities
Think about what has made you feel the way you do and see if you can react differently
Take a 10-minute walk, exercise or stretch to reduce tension

What are some good ways of calming others?

Listen to people who want to talk and share their emotions and experiences with you
Do not try to force people to talk about things they do not want to talk about
Be friendly and compassionate even if people are being difficult (this can help them and you)

Additional material:

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[Five Principles of Psychological First Aid \(PFA\)](#)
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[Overcoming Difficult Events – Reactions, Responses and Examples](#)

► How do I know if I or someone I care about needs help?

► What does being connected with others mean and what can it do for me?

► Why is it important to support others?

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Workshop 3

▼ What is self-efficacy?

What is self-efficacy?

Self-efficacy is a belief in your own capacity to achieve goals
It can also be a belief in the capacity of a group (such as a unit or a family)

Why is self-efficacy important?

It can help you cope with challenging events in the future
It can reduce negative feelings about yourself, your family or your unit
It can help you control your emotions when you feel discouraged
If you believe in your ability to achieve goals, you are more likely to achieve them

You can improve your self-efficacy through:

1) Solving Problems

Realize that you have succeeded before on other tough jobs
Break large tasks down into small tasks that you can achieve
Apply what you know to new situations
Build on the strengths you already have
When you need it, seek out help that will get you to your goal
You do not always have to "go it alone" to be successful

2) Helpful Thinking

Understand how your emotions affect your thinking
Take note of and appreciate your own personal strengths
Help others solve problems (this can suggest new things for you too)

How can I help others with their self-efficacy?

Help them remember how they have done well in the past
Help them find their own strengths and use them
Remind them to use their own strength in the future

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▼ Why are hope and optimism important?

▼ How can hope and optimism help me?

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Workshop 4

- ▶ What are the five principles of Psychological First Aid (PFA)?
- ▶ Why are the principles of PFA important?
- ▼ How do I use the principles of PFA?

How do I use the principles of PFA?

Safety - Pay attention to your feelings of being safe or being in danger. Learn to recognize your emotions when you are not really in danger, but feel threatened. Avoid situations that are risky or threaten your safety

Calming - You can use your thoughts (peaceful scenes) and relaxation techniques (breathing) to calm down, feel more comfortable and control your reactions

Connectedness - Seek out and spend time with people you feel comfortable with. Do things that you enjoy with others

Self-efficacy - Think about how you have succeeded before on other tough jobs. Use the strengths you already have and build new ones

Hope and optimism - Look for meaning in events and benefits that you can get from dealing with a tough situation

Additional material:

- [Resources at Fort Lee and the Surrounding Area](#)
- [Returning Home – Advice for Soldiers](#)
- [Overcoming Difficult Events – Reactions, Responses and Examples](#)
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D2. Handout – Acute Stress Disorder and Post Traumatic Stress Disorder



Troop Education for Army Morale



Acute Stress Disorder (ASD) and Post Traumatic Stress Disorder (PTSD)

Both ASD and PTSD are reactions to traumatic events. While doctors will make some specific distinctions between them, the biggest difference is the time course. ASD is a short-term reaction to trauma lasting less than 30 days, while PTSD technically only occurs 30 or more days after a traumatic event. Both ASD and PTSD have similar symptoms. These are:

- Feeling detached, that things are not real, and forgetting that traumatic events happened
- Feeling like you are re-experiencing the traumatic event
- Avoiding reminders of the event or feeling numb
- Feeling highly jumpy or on-edge after the event

If you or someone you know indicates they are experiencing these feelings and behaviors, it is important that they get a medical evaluation to identify potential health issues. There are two important steps in managing ASD or PTSD: assessment (evaluation) and treatment. There can be several steps in both.

Assessment — Psychological effects may result from physical injury. An initial psychological evaluation to determine the first reaction to a trauma can be conducted while the person is still undergoing treatment for a physical injury. Once the physical injury has been stabilized, a more detailed psychological evaluation can be conducted.

Treatment — Initial objectives for persons with ASD or PTSD include establishment of a therapeutic relationship with a health care provider, addressing other problems that may come up, co-morbid disorders, and undertaking a therapy program. Therapy can include talk therapy and medication. Talk therapy often consists of cognitive-behavioral therapy to explore how the person's thought processes influence their reaction to the traumatic event and behavioral means to change patterns of behavior that are causing the person problems. Medication can also be given to treat some of the symptoms. Medications for ASD and PTSD should be prescribed by a physician and the person's response should be carefully watched by the doctor. A combination of psychotherapy with drug therapy has been more effective for some persons than drugs alone. The course of treatment with both talk therapy and medication can be short or long depending on the person's reaction to the traumatic event. It is generally believed that most people with ASD or PTSD will benefit from treatment.



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D3. Handout – Leadership During Mortuary Affairs Operations



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Leadership During Mortuary Affairs Operations

Although Mortuary Affair Soldiers have been trained in their MOS, people will show different reactions. This is particularly true for personnel new to the field. In the current Middle East war, people will often work for long periods of time in isolation from other Soldiers. They will also be supported by another military service such as the Air Force and have difficulty communicating with their Army supervisors who may be many kilometers away.

Some people will have the same reactions and feel the same emotions, while others will have unique stresses. Leadership involves knowing about and recognizing stress in your personnel in order to accomplish your mission and maintain morale.

The following practices may help minimize difficulties on site and afterwards. The quality of leadership, both good and bad, is always recognized and remembered.

- Assure that Soldiers are working under proper authority and leadership.
- Assure that adequate logistical support is provided by the supporting organization. This includes technical equipment such as refrigeration and transportation as well as personal protective equipment.
- Assure the health and welfare of the Soldiers with facilities for getting adequate rest and facilities for personal hygiene.
- Do not let outside authorities take over or influence the timing or quality of operations. (Units may want to take over handling the remains of their own Soldiers. Leadership must assure that this does not happen.)
- If the mission allows, let people vary their jobs and work hours so they can adjust to different stresses such as fatigue, less than adequate support, and operational demands.
- Each person will have a personal way of approaching the job. It is not advisable to expect the same feelings or actions of everyone. Try to understand the reactions and feelings of each Soldier.
- Soldiers should be advised not to "personalize" the bodies or the situation. They can be told, "Think of it as a job!"
- Provide a rest area for Soldiers away from the collection point or mortuary with food, drink, cots, facilities for washing and showering, changes of clothing and protection from outside interference.
- Leaders such as Army NCOs and officers should visit the work areas frequently and engage talk to the Soldiers about their work and their support.
- VIPs who visit the collection point or mortuary should be advised to treat the remains, the facility, and the Mortuary Affairs Soldiers with respect.
- Praise people's work and reward their efforts. Awards, certificates and letters are appreciated and appropriate. Do not forget to say "Thank you" personally and as often as possible.



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D4. Handout – Leadership Stress Management



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Leadership Stress Management

Leadership is paramount in maintaining organized, efficient work. One of the tasks of being a leader is being aware of your own level of stress and taking appropriate measures before problems begin. In order to take care of others you must first take care of yourself. It is difficult to predict the kinds of psychological problems that any individual leader will have, however, the following plans can help minimize stress. The following points are directed at actions leaders should take for themselves. However, they are often the same steps you must insure that you provide for your subordinates.

- Establish a work-rest schedule and follow it
- Take breaks where you get off your feet
- Use a rest area with food and drinks and shielding from outside interference
- Eat and drink on a regular schedule — take every opportunity to assure that you are hydrated
- To avoid dehydration, drink BEFORE you are thirsty
- Caffeine can jangle the nerves and dehydrate you
- Avoid all beverages containing alcohol
- Avoid smoking
- In a time of terrible demand, moderation is still a virtue
- When you notice that others are stressed, ask yourself if you are stressed, too
- Identify a trusted co-worker who can evaluate your level of effectiveness and consult with him or her on a frequent basis
- Provide a similar service to a co-worker who trusts you
- Communicate clearly in an optimistic manner but be sure to identify mistakes clearly for yourself and others and correct them
- Compliments can serve as powerful motivators and stress moderators
- To reduce stress for others, lead by example



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D5. Handout – Parenting Tips for Managing Difficult Events



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Parenting Tips for Managing Difficult Events

During and after difficult events the needs of children and adolescents are likely to change. Children and adolescents may need more information to understand what is happening and help coping with the event. They will look to parents to provide information and guidance. Increasing the level of communication and paying special attention to what you say and how you say it are very important.

It is difficult to predict the kinds of problems that children and adolescents will have, but ensuring physical safety and security is the first priority. Your response to the situation will also affect your child's response. It can be helpful to consider your own response and to discuss your own reactions with another adult before talking with your children.

The following suggestions may help the present situation and minimize later difficulties:

- Discuss the event in an open honest manner with your children.
- Do not avoid answering questions directly.
- Be patient. Children might want to talk, interrupt or not pay attention. They may need to have concrete information repeated.
- Maintain daily routines to the fullest extent possible. For children, school is an important part of feeling safe and normal. Familiar schedules and bedtime stories can be reassuring.
- Every child has a different way of responding to difficult situations. Listen to your child's stories.
- Engage your child in conversations of their choosing. Talking about the normal events of life can be central to healthy functioning.
- Increase your child's sense of control and mastery within the household – for example, let children plan dinner or other activities.
- Some children may temporarily return to old behaviors such as a loss of toilet training.
- Limit your children's times of exposure to television or other sources of information that can cause further distress.
- Reassure your children that the situation was not their fault.



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D6. Handout – When Your Loved One Returns Home



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When Your Loved One Returns Home

Families and friends of returning Soldiers often wonder what to expect after their loved one comes home from a combat zone. They may ask "What is typical?" and "Should I be concerned?" It is not uncommon for people who have been involved in high stress situations to have distress responses. These may be physical or emotional in nature and are usually only temporary. What are some warning signs that may signal problems? To have one or more of the following after return from deployment is not unusual, but watch for problems that do not go away.

Sleep: Difficulty falling asleep; staying asleep or waking early and not being able to get back to sleep.

Restlessness: Being jittery, fidgety or showing a high degree of nervous energy.

Overly Watchful or Hypervigilant: Oversensitivity or anticipation about things in the environment (e.g., noise, physical objects) that are viewed as a threat to personal safety.

Social Withdrawal: Avoiding family or friends, always wanting to be alone, avoiding social activities that he/she used to enjoy.

Cigarette Smoking: Often starts or increases in the combat zone, and continues or increases upon return home.

Alcohol Use: Alcohol use may start or continue as a means of reducing stress.

Reckless Driving: Risky driving may have been a skill in the combat zone, but it is dangerous on U.S. roads. Stress and alcohol can also contribute to risky driving.

Violence: Irritability or anger can turn into violence creating a risk for the Soldier and the family. Mixing anger with alcohol can be particularly risky. Conflicts that become violent need to be recognized as serious problems in need of help. When violence occurs in families, children are particularly at risk and need to be protected.

Depression: Sense of sadness, guilt or failure that does not improve. Thoughts of death or a wish to no longer be living is very serious. Family and friends should call a doctor or 911 immediately.

Social Withdrawal: A strong desire to avoid other people.

Personal Changes: Headaches or unexplained changes in personality or thinking.

Flashbacks: Unwanted and unsettling memories that continue after coming home.



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D7. Handout – When Terrible Things Happen: What You May Experience



Troop Education for Army Morale

When Terrible Things Happen: What You May Experience

Sometimes terrible things happen. During or immediately after a terrible event individuals may experience a wide variety of positive and negative reactions. These can include:

Domain	Negative Responses	Positive Responses
Cognitive	Confusion, disorientation, worry, intrusive thoughts and images, self-blame	Determination and resolve, sharper perception, courage, optimism, faith
Emotional	Shock, sorrow, grief, sadness, fear, anger, numb, irritability, guilt and shame	Feeling involved, challenged, mobilized
Social	Extreme withdrawal, interpersonal conflict	Social connectedness, altruistic helping behaviors
Physiological	Fatigue, increased heart rate, headache, muscle tension, stomach ache, exaggerated startle response, difficulties sleeping	Alertness, readiness to respond, increased energy

Common Negative Reactions that May Continue Include:

Intrusive reactions

- Distressing thoughts or images of the event while awake or dreaming
- Upsetting emotional or physical reactions to reminders of the experience
- Feeling like the experience is happening all over again ("flashback")

Avoidance and withdrawal reactions

- Avoid talking, thinking, and having feelings about the traumatic event
- Avoid reminders of the event (places and people connected to what happened)
- Restricted emotions; feeling numb
- Feelings of detachment and estrangement from others; social withdrawal
- Loss of interest in usually pleasurable activities

Physical arousal reactions

- Constantly being "on the lookout" for danger, startling easily, or being jumpy
- Irritability or outbursts of anger, feeling "on edge"
- Difficulty falling or staying asleep, problems concentrating or paying attention

Reactions to trauma and loss reminders

- Reactions to places, people, sights, sounds, smells, and feelings that are reminders of the event
- Reminders can bring on distressing mental images, thoughts, and emotional or physical reactions
- Common examples include: sudden loud noises, sirens, locations where the event occurred, seeing people with disabilities, funerals, anniversaries of the event, and television/radio news about the difficult event

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When a loved one dies, common reactions include:

- Feeling confused, numb, disbelief, bewildered, or lost
- Feeling angry at the person who died or at people considered responsible for the death
- Strong physical reactions such as nausea, fatigue, shakiness, and muscle weakness
- Feeling guilty for still being alive
- Intense emotions such as extreme sadness, anger, or fear
- Increased risk for physical illness and injury
- Decreased productivity or difficulties making decisions
- Having thoughts about the person who died, even when you don't want to
- Longing, missing, and wanting to search for the person who died
- Children and adolescents are particularly likely to worry that they or a parent might die
- Children and adolescents may become anxious when separated from caregivers or loved ones

Common Positive Reactions that May Continue Include:

Positive changes in priorities, worldview, and expectations

- Enhanced appreciation that family and friends are precious and important
- Meeting the challenge of addressing difficulties (by taking positive action steps, changing the focus of thoughts, using humor, acceptance)
- Shifting expectations about what to expect from day to day and what is considered a "good day"
- Shifting priorities to focus more on quality time with family or friends
- Increased commitment to self, family, friends, and spiritual/religious faith

WHAT HELPS

- Maintaining a normal schedule
- Exercising in moderation
- Spending time with others
- Scheduling pleasant activities
- Taking breaks
- Seeking counseling
- Keeping a journal
- Participating in a support group
- Engaging in positive distracting activities (sports, hobbies, reading)
- Focusing on something practical that you can do right now to manage the situation better
- Getting adequate rest and healthy meals
- Talking to another person for support
- Reminiscing about a loved one who has died
- Using relaxation methods (breathing exercises, meditation, calming self-talk, soothing music)

WHAT DOESN'T HELP

- Using alcohol or drugs to cope
- Working too much
- Withdrawing from pleasant activities
- Not taking care of yourself
- Overeating or failing to eat
- Doing risky things (driving recklessly, substance abuse, not taking adequate precautions)
- Extreme withdrawal from family/friends
- Blaming others
- Extreme avoidance of thinking or talking about the event or a death of a loved one
- Violence or conflict
- Excessive TV or computer games

D8. Handout – What Military Families Should Know About Depression



Troop Education for Army Morale



What Military Families Should Know About Depression

Service members and their families experience unique emotional challenges. Deployment, single parenting and long absences from loved ones are a stressful part of military life. Sometimes, these challenges can lead to sadness, feelings of hopelessness, despair, and withdrawal from friends, families, and colleagues. At these times, parenting may feel like more of a burden than a joy. You may feel irritable and even neglectful of your needs and those of your children. When these feelings and behaviors appear, depression may be present.

The following information will help you talk about depression with healthcare providers, family members and friends. This information might help you or someone else to identify depression and seek help.

What is Depression?

Depression is a *medical* illness and a *treatable* illness just like diabetes or heart disease. It involves one's body, mood, and thoughts. It affects the way a person eats and sleeps, the way one feels about oneself, and the way one thinks about things. Depression can also take the form of chronic fatigue or unexplained aches and pains. Depression is not just a passing blue mood, nor is it a sign of personal weakness. Individuals who are depressed often experience more difficulty in performing their job, caring for children, and in maintaining personal relationships.

Women experience depression about twice as often as men. Some women are particularly vulnerable after the birth of a baby. The hormonal and physical changes as well as the added responsibility of a new life can be factors that lead to postpartum depression. While it is normal for a new mother to have a temporary case of the "blues," a severe depression is not normal and requires intervention. For men, depression often shows up in the form of alcohol or drug use and working long hours. Men may act irritable, angry, and discouraged when they are depressed. Men are often less willing than women to seek help. A family history of depression and negative life experiences such as loss, trauma, serious illness and stress can contribute to the onset of depression.

Signs and Symptoms of Depression

There are some common signs that might indicate depression, but getting a doctor's opinion is the first step to evaluation. Signs and symptoms include:

- Persistent sad or empty mood
- Loss of interest or pleasure in activities
- Changes in appetite (reduced or increased appetite) or sleep (reduced or increased sleep)
- Decreased energy or fatigue
- Inability to concentrate, make decisions
- Feelings of guilt, hopelessness or worthlessness
- Thoughts of death or suicide

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Symptoms of depression in young children include:

- Physical symptoms, like chronic headaches or stomachaches that cannot be attributed to a physical illness.
- Aggression and excessive crying
- Irritability, withdrawal, isolative behavior, loss of interest and/or pleasure in activities.
- Sleep disturbance, changes in appetite and reduced energy.

Children with other psychiatric disorders (hyperactivity, conduct disorder, eating and anxiety disorders), developmental disorders or mental retardation, and those with general medical conditions (diabetes, asthma, cancers and other chronic illnesses) may be more prone to depression.

Symptoms of depression in adolescents include:

- Loss of interest in school and regular activities; drop in school performance
- Withdrawal from friends and family
- Negative thoughts of self and future
- Difficulty making decisions

Depression in older adults:

Depression in older adults can be complex and disabling. There are similarities between depression and other medical problems such as dementia, stroke, and other types of brain injuries and illnesses, which may make depression difficult to recognize.

Seeking Medical Care for Depression

There are effective treatments for depression including medications and therapy. The majority of people who are treated for depression will improve, even those with serious depression. Without treatment, symptoms can last for weeks, months, or years. Unfortunately, many people do not realize depression is a treatable illness and only one-third of sufferers seek help. Delay in identifying depression often leads to needless suffering for the depressed individual and the family. The earlier depression is detected and treated, the less likely it is to develop into a serious problem that can affect one's health, relationships, and career.

Important Tips for Managing Depression

- Get adequate rest
- Participate in regular exercise
- Communicate with people who are important to you
- Communicate your feelings to someone whom you trust
- Manage your diet and avoid excess alcohol
- Join a social support group in your military community or in your local area

The Bottom Line

Depression is not uncommon during stressful times, particularly during periods of adjustment such as deployment and return from deployment. Appropriate treatment is available and can help most people who suffer from depression. Seeking care for depression takes energy and courage. A primary care visit is an opportunity to explore concerns about the mental health of your spouse, yourself, or your children.

D9. Handout – Checklist for Health and Personal Care Information When Moving



Troop Education for Army Morale

Checklist for Health and Personal Care Information When Moving

Military families move around the nation and around the globe. While relocation is a part of military life and military tradition, the process is stressful, especially during wartime. Here are some tips that will help you remember and address some practical health care issues when you are preparing to move.

Yes No

- Obtain information about how to get TRICARE or other medical care en route to a new duty station, if needed.
- Secure your own and your family's medical records.
- Important documents such as birth certificates, immunization records, social security cards, passports, naturalization papers and school records should be carried with you and not shipped.
- Carry your orders with you.
- Obtain medication refills in case moving or arrival is delayed.
- Information on support services for children with special needs should be obtained and, if possible, set up before departing from the old duty station.
- Take care of needs of pets and carry their food and other care items and vaccination records with you.



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D10. Handout – Connecting with Others: Seeking Social Support



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Connecting with Others: Seeking Social Support

Social support is related to emotional well-being. After experiencing difficult events, connecting with others can reduce feelings of distress and aid recovery. Supportive contacts can be sought from a variety of sources.

Social Support Options

- Spouse or partner
- Parents
- Children
- Other family member
- Priest, Rabbi, or other clergy
- Close friend
- Neighbor
- Co-worker
- Crisis counselor or other counselor
- Doctor or nurse
- Support group
- Pet

Do...

- Decide carefully whom to talk to
- Decide ahead of time what you want to discuss
- Choose the right time and place
- Ask others if it's a good time to talk
- Let others know you need to talk or just be with them
- Start by talking about practical things
- Tell others what you need or how they could help
- State one main thing that would help you right now
- Talk about painful thoughts and feelings when you are ready
- Tell others you appreciate them listening

Don't...

- Keep quiet because you are worried about being a burden
- Wait until you are so stressed or exhausted that you can't fully benefit from help
- Keep quiet because you don't want to upset others
- Assume that others don't want to listen or help

Ways to Get Connected

- Call friends or family on the phone
- Increase contact with existing acquaintances and friends
- Get involved in community activities
- Attend church, synagogue or other religious activities



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D11. Handout – Five Steps to Getting Support



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Five Steps to Getting Support

1. **"What Do I Want?"** The first step is to figure out what you really want or need. For example, sometimes we want to be understood, and sometimes you want advice. There are two parts to this:
 - A. **Look Outside Yourself:** What kind of problem am I facing that I may need support from others to cope with? For example:
 - Do I have to make an important decision (so that I need some good advice?)
 - Do I need someone to help me do something?
 - Do I need someone to give me something?
 - B. **Look Inside Yourself:** What am I thinking and feeling inside that I may need support from others to cope with?
 - Do I want someone to just listen and try to understand what I'm going through?
 - Do I want a hug from someone?
 - Do I want companionship?
 - Do I want encouragement that I can handle a difficult situation?
 - Do I want reassurance that people will be there for me?
 - Do I want someone to help me get my mind off my problems?
2. **"Whom Should I Ask?"** The second step is to think about who has been, or could be, a good source of support for what you want? You need to ask yourself:
 - Who has been a good source of this type of support in the past?
 - Do I have others that I can depend on to provide this type of support? For example, even if you have never gone to him/her to talk before, do you have an aunt or uncle whom you think would be a good listener?
 - Do I need to seek new supports to meet a need? For example, if I want someone to talk to, are there people I know, or people around me, whom I could start spending time with?
3. **Find the Right Time.** Because you will be talking to the person about something that matters to you, you want him/her to have enough time to listen. Choose the right time and place to approach the person by asking them this question.
4. **Request With an "I"-Message.** Once you have decided what type of support you wish to receive, whom to ask, and have found a good time to talk, use an "I"-message to communicate the following:
 - How you're feeling
 - About your situation
 - What you want him/her to do
5. **Thank the Person.** End the conversation thanking the person for listening or for how you were helped. Be specific so he/she knows how to help in the future.

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Social Support Information

Social support is one of the most consistently identified protective factors for combating stress and improving resiliency. Social support allows people to:

- Increase opportunities for knowledge and problem solving
- Share experiences and concerns
- Feel needed and wanted
- Feel understood and cared for
- Feel like one fits in and belongs
- Feel reassured that friends and family will be there for you if needed
- Build up confidence that you can handle the problems you are facing
- Get good advice when confronted with a difficult situation

Seeking support is vital in some instances:

- Alcohol or drug problems
- Domestic, child, or elder abuse
- An acute mental health problem (threat of harm to self or others)
- Acute medical problem
- Significant developmental concerns about children or adolescents
- Ongoing problems (still having problems 4+ weeks after a difficult event)
- When pastoral counseling is desired

There is a variety of different kinds of support including:

- Emotional support: hugs, a listening ear, understanding, love, acceptance
- Social connection: feeling like you fit in and have things in common with other people, having people to do things with
- Feeling needed: feeling that you are important to others, that you are valued, useful and productive, and that people appreciate you
- Reassurance of self-worth: having people help you build/maintain confidence in yourself and your abilities, that you can handle the challenges you face
- Reliable support: having people you can rely on to help you in case you need them
- Advice and information: having people give you information, advice, instruction, good examples of positive coping, or help understanding that your reactions to difficult events are normal
- Physical assistance: having people help you do things (like carry or fix things or help with paperwork)
- Material assistance: having people give you things, like food, clothing, shelter, or money

There is also a variety of sources of support including persons with whom you have a primary relationship (e.g., spouse/partner, children, parents, other family members, close friends, and neighbors) and those outside the primary relationship such as co-workers and hobby or club members (e.g., VFW, Rotary, or book club). During and after difficult events people may rely more on religious and spiritual beliefs/practices to cope with ongoing challenges. Your higher power, clergy and fellow church members can be another good source of support.

Some problems require specific kinds of support. One type of support (like financial advice) can be very helpful in dealing with financial problems, but not helpful in dealing with other problems (like relationship problems). It is best when there is a good match between what the problem demands and what the supporter can provide.

D12. Handout – Tips for Couples after Returning from Deployment



Troop Education for Army Morale



Tips for Couples after Return from Deployment

Coming together as a couple after deployment is not always easy or something that happens naturally. It requires effort and an understanding that each person has grown and changed during the separation. A positive way to think about this is that both of you have developed your own means of coping with experiences while apart. What is important now is to work together. Here are four steps to help you.

Step 1: Understand what happened to each other during the separation

Soldiers may have:

- Been affected by events that can be difficult to talk about
- Had positive and negative interactions with unit members
- Had routines of work and rest that are different from home
- Heightened sensitivity to particular sights, sounds and smells
- A different sense of self based on war experiences

Spouses may have had new or more stressful experiences with:

- Employment – Could have added pressure, but also could have been a source of support
- Finances – Was tough to manage all finances alone, but could have learned to manage money very well
- Children – Care of children was difficult alone, but could have developed some strong bonds with them
- In-laws – Relationships may have changed for better or for worse

Step 2: Relationship Breakers. Most couples argue about intimacy, money or children.

These have the potential to unite or divide:

- *Intimacy*. Intimacy is a combination of emotional *and* physical togetherness. It may not be easily re-established after separations. Partners may also experience high or low sexual interest causing disappointment, friction or feeling rejected. For example, medications, fatigue, and alterations in sleep cycles can sometimes affect desire and performance.
- *Finances*. During the deployment, most service members and families received additional income from tax breaks and combat duty pay. Some families may have saved while others may have spent some or all it. Regardless of which occurred, the present need is to establish a sound financial plan.
- *Children*. Children have grown and changed during deployment. Some returning Soldiers will see children for the first time. It is important to build upon the positive changes in your children, and work as a couple to address concerns. Discipline of children will now be shared.

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Step 3: Recognize the mutual adjustments now needed:

- *Home*. Recognize that home routines will change. Keep communication open as you adjust to your new schedules and duties.
- *Children*. Children act differently depending upon their age. Changes in duties, privileges, and discipline may have to be worked out. New bonds with them may have to be established.

Step 4: Relationship Makers. Here are some thoughts and tips:

- *Communicate*. Sometimes talking requires courage. Listen to your partner. Let him or her talk about topics of their own choosing. Do not force the conversation. Neither person should be offended by a reluctance to discuss experiences. However, do not neglect issues that have to be discussed.
- *Enjoy life*. Find activities that are fun and do them as a couple or a family. Other activities may involve physical activity such as taking walks, working out together, or playing sports. You may also want to read, draw, paint, dance, sing, play an instrument, or volunteer somewhere.
- *Give thanks*. Thank people who have helped you and your family during this deployment. Showing appreciation through will help you share each other's experiences.
- *Let time be your friend*. Give yourself and your spouse time. Time is often one of the most important factors in healing and solving problems.
- *Be positive*. A positive attitude is one of the most important gifts you can bring to each other and your family.
- *Expectations*. If tempers become short, take a break and return to discussions when you feel more relaxed.
- *Know when to seek help*. If either Soldier or spouse suspects they may be suffering from a health or mental health problem, it is essential to seek help. Many service members do not want to seek help for mental health problems from the military for fear of damaging their career. However, the consequences of letting a problem linger untreated can be much more damaging.

D13. Handout – Helpful Thinking



Troop Education for Army Morale

Helpful Thinking

An individual's appraisal of a situation results in an emotional experience. Appraisals are different from feelings. Appraisals are the thoughts or beliefs that run through a person's head as they consider a situation. Emotions result from the appraisals.

After difficult events, it is common for some of the appraisals an individual makes about the world and about him or herself to change. Usually, the changes in view are extreme and not entirely accurate. These distorted appraisals can be hard to alter unless the individual becomes aware of them. Once aware, the individual can then challenge the present view with new appraisals that are more realistic. This is achieved in several steps:

1. Understand how appraisals influence your emotions
2. Increase awareness of the appraisals that cause an excessive negative reaction. For example, "What do you think about what happened during/after a difficult event?" "How has it affected you?" "What goes through your mind when you think about the event and your current situation?"
3. Identify the emotions that arise when you make an unhelpful appraisal
4. Consider replacing these appraisals with more helpful thoughts (which will lead to new emotions)
5. Create a more helpful appraisal, understand the different emotional consequences that result

The following table outlines some of the more common unhelpful appraisals that lead to some of the emotional distress experienced after a difficult event. The table also includes some examples of alternative appraisals that can lead to less emotional distress.

Unhelpful Appraisals	Resulting Emotion	Alternative Appraisals	New Emotional Response
Control			
"I have no control over anything"	Helplessness; apathy; confusion; frustration	"I can control some decisions about my future" "Doing things gives me a greater sense of control" "Talking to someone about my problems shows I have some control!"	Purposeful; hopeful; goal-oriented; less helpless
"I can't cope"	Helplessness; incompetency; fear	"The fact I got here today shows that I am coping a bit" "Everybody would have trouble after this event"	Less fearful; less helpless; oriented to seek help/support
Safety			
"The world is a dangerous place"	Scared; anxious; mistrustful	"The world can offer good possibilities" "The world is not always dangerous" "There are good people and bad in the world" "Most of the time I am safe"	Hopeful; trusting of people who will help; active about future
"I can't trust anyone"	Lonely; sad; withdrawn; suspicious	"Trusting people has led to me getting help" "I don't need to be mistrustful of everyone" "I can choose some people to trust!"	More trusting; less suspicious; hopeful; optimistic

(Table continues on back side)



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*Training material adapted from the National Center for PTSD and National Child Traumatic Stress Network's Psychological First Aid (2008) and Skills for Psychological Recovery (2007) Field Guides

Defense Centers of Excellence
for Psychological Health
and Traumatic Brain Injury



Unhelpful Appraisals	Resulting Emotion	Alternative Appraisals	New Emotional Response
"I'm not safe"	Anxious; fearful; insecure	"Feeling unsafe isn't the same as being unsafe" "A bad thing has happened but it doesn't mean it will happen again"	Self-assured; more relaxed
<i>Blame</i>			
"This is unfair"	Angry; vengeful	"This could have happened to anyone" "Sometimes bad things happen to good people"	Understanding; realistic; resigned
"I should have prevented this"	Guilty; frustrated; low self-esteem; upset	"Nobody could have prevented this" "I can't always protect others"	Intact self-esteem; accepting
"I should have done more"	Guilty; frustrated; upset	"At the time I did the best I could" "I would not expect anyone else to have done more than I did"	Able to move on; reduced distress
"It's their fault this happened"	Angry; frustrated; vengeful; dislike; distrust	"Blaming people doesn't change my situation"	Optimistic; accepting
"Things will never be the same again"	Sad; regretful; hopeless	"Feeling really bad usually doesn't last forever" "Thinking like this makes it difficult to plan for the future"	Future-oriented; accepting

Buddy Care: Helping Your Buddy Solve Problems

Solving problems can be difficult under conditions of stress and adversity. When your buddy is facing adversity, providing resources, helping to address identified needs and helping to set achievable goals can reverse feelings of failure and inability to cope, and increase a sense of hope, dignity, empowerment and control. The following four steps can be used to assist you in helping your buddy:

Step 1: Identify the most immediate needs: If a buddy has identified several needs or current concerns, it will be necessary to focus on them one at a time. First, work on those issues requiring immediate attention. For some needs, there will be immediate solutions (e.g., getting something to eat). Other needs will not be solved quickly (e.g., obtaining needed health care services after returning from deployment), but you may be able to help your buddy take concrete steps to address the problem (e.g., setting an appointment for health care services).

Step 2: Clarify the need: Specify the problem. If the problem is understood and clarified, it will be easier to identify practical steps that can be taken to address it.

Step 3: Discuss an action plan: Discuss what can be done to address your buddy's need or concern. Your buddy may say what he/she would like to be done, or you can offer a suggestion. If you know what services are available ahead of time (e.g., financial assistance, medical or mental health care, or spiritual care services), then you can aid in obtaining those services. Discuss what can be expected in realistic terms.

Step 4: Act to address the need: Help your buddy to take action (e.g., help him/her set an appointment or complete paperwork).

Appendix E – Survey Questionnaires

- E1. Intervention and Comparison Group Month 1 (Baseline) Questionnaire**
- E2. Intervention Group Month 2 Questionnaire**
- E3. Intervention Group Month 3 through Month 10 (Final Survey) Questionnaire**
- E4. Comparison Group Month 2 through Month 10 (Final Survey) Questionnaire**

E1. Intervention and Comparison Group Month 1 (Baseline) Questionnaire

Mortuary Affairs Questionnaire

Please Return to:

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Uniformed Services University of the Health Sciences
4301 Jones Bridge Road
Bethesda, Maryland 20814-4799

Stress and Resiliency in U.S. Army Mortuary Affairs Soldiers
Uniformed Services University, Bethesda, MD

INFORMED CONSENT INFORMATION

This anonymous questionnaire is part of a research project designed to determine the health and performance in Mortuary Affairs (MA) soldiers who might deploy to the Middle East. The study is being conducted by the Center for the Study of Traumatic Stress, Uniformed Services University, located in Bethesda, MD.

You are being asked to participate in this questionnaire because you might deploy or have returned from deployment to the Middle East. Approximately 500 soldiers per year from the 54th, 500 soldiers per year from the 111th, 300 soldiers per year from the 311th and 300 soldiers per year from the 246th QM Companies may take this questionnaire, and in the future you may be invited to take follow-up questionnaires. Your responses will be combined with others and analyzed to discover group level information about health and performance in Mortuary Affairs soldiers.

In the questionnaire you will be asked questions about your preparation for deployment, deployment experience, training, health practices such as smoking, drinking, sleep patterns and daily activities. The questionnaire will take about 20 minutes to complete.

Participation in this study is voluntary and anonymous. You may refuse to participate in this study or discontinue participation at any time. There are no consequences to you for refusing to participate. You will indicate consent by filling out the questionnaire. You do not have to answer any questions that make you feel uncomfortable, however, by not responding to all the questions limits what we can use from your questionnaire. You may discontinue participation in this study at any time.

Confidentiality: The information you provide will not be linked to you in any way. The information you provide is not associated with your name (we do not ask for names) or any personal information that could be identified with you personally. Access to questionnaire responses collected in this study is restricted to members of the project staff at the Center for the Study of Traumatic Stress, Uniformed Services University, and the USUHS IRB personnel who may review project files as part of their duties to protect human participants in research. All information will be kept confidential to the full extent provided by law.

Benefits and Risks of Participation in this Study: There are no direct benefits to you for participating in this study. Your responses may help scientists studying group responses to being a MA soldier and deployment. The results of this study will be shared with others through publication in the scientific literature and in other publications. Some individuals may experience an emotional response during completion of questionnaires. If you have been feeling generally worse than you normally do, you may wish to contact your primary health care provider, a medical officer or chaplain. If you need a referral to a mental health professional in your area you may call the American Psychiatric Association at 1-888-357-7924 and select option “0” for an answer center coordinator. The coordinator will provide a referral for a mental health professional in your area.

If you have questions about this study: If you have questions about this study you may contact the study Principal Investigator, Dr. Robert J. Ursano, Uniformed Services University, 301-295-3293.

Mortuary Affairs Questionnaire

INSTRUCTIONS

During the past several years the U.S. Army Mortuary Affairs soldiers have had many operational deployments. Preparing for deployments, actual deployment and return from deployment present many challenges for soldiers, families, units and communities. The purpose of this questionnaire is to learn more about the experiences of MA soldiers. Through this questionnaire, you will help us and the Army learn more about MA soldiers the effects of deployment on you and persons like you. Therefore, your responses are especially important to us to better prepare MA soldiers for future assignments.

Please read instructions for each item carefully before you answer. There are no right or wrong answers to the questions. Just answer the questions the way you feel about them. The important thing is to **ANSWER ALL QUESTIONS COMPLETELY**. Most questions can be answered by circling a number corresponding to a ready-made answer or by filling in a blank or writing in a brief description. Unless otherwise instructed, please give only one answer for each question.

We are interested in possible **follow-up questionnaires in the future**. In order to be able to match this questionnaire with any future follow-up questionnaires while protecting your identity, we are asking you to provide the information below to create a unique identifier for you (see examples for each item). We will ask you these same questions on future questionnaires.

1. **Last letter** of your mother's maiden name: _____ (e.g., for "Smith" put "h") (1)
2. **First letter** of the city you were born in: _____ (e.g., for "Baltimore" put "B") (2)
3. **First letter** of the month you were born: _____ (e.g., for "July" put "J") (3)
4. **Last digit** of the **day of the month** you were born: _____ (e.g., for "06 July" put "6", or for "12 July" put "2") (4)
5. **Last digit** of the **year** you were born: _____ (e.g., for "1976" put "6") (5)

(6-8B)

PART I. BACKGROUND INFORMATION

Please answer the questions below by filling in the blanks or circling the number of the response that best applies.

- A 1. Today's Date: D D / M M / Y Y (9-14)
- A 2. Your Age: ____ years (15-16)
- A 3. Your Sex: 1. Male 2. Female (17)
- A 4. Your Pay Grade (*e.g., E-5*): ____ - ____ (18-19)
- A 5. Your Brigade or Separate Unit: _____ MOS: _____ (20-24)
- A 6. Highest level of education you have completed: (25)
1. Less than 12th grade
2. High School or G.E.D.
3. Some College/Technical school
4. Bachelor's Degree
5. Graduate Degree (Masters or doctoral)
- A 7. Racial/Ethnic Background: (26)
1. American Indian or Alaskan Native
2. Asian or Pacific Islander
3. Black, not of Hispanic origin
4. Hispanic
5. White, not of Hispanic origin.
- A 8. Are you currently Married? (27)
1. Yes, number of years: ____ (28-29)
2. No
- A 9. Do you currently live with your Spouse? (30)
1. Yes
2. No
3. Not Applicable (*not married*)
- A 10. Do you currently live with a Significant Other (*not including spouse, parents or children*)? (31)
1. Yes, number of years: ____ (32-33)
2. No
- A 11. Do you have children? (34)
1. Yes, Number of children who lived with you during the past 12 months: ____ (35)
2. No

A 12. Is your Spouse/Significant Other (SSO) active duty military? (36)

1. Yes
2. No
3. Not Applicable

A 13. Have you ever seen or worked with dead bodies? (37)

1. Yes
2. No

A 14. Have you ever seen a dead body which had been violently killed? (38)

1. Yes
2. No
3. NA, I have never seen or worked with dead bodies

A 15. In the past **12 months**, have you ever **Deployed** for **2 weeks or more** for: (39)

- a. Training: 1. Yes 2. No (40)
- b. Combat, Peacekeeping, disaster or Mortuary Work: 1. Yes 2. No (41)

A 16. Have you ever deployed to the Middle East (*Iraq, Afghanistan, Kuwait, and other countries of the region*)? (42)

1. Yes
2. No

If Yes: Date of your **most recent Deployment** to the Middle East: ____ / ____ / ____
D D M M Y Y (43-48)

Date you **Returned** from your **most recent Deployment** to the Middle East: ____ / ____ / ____
D D M M Y Y (49-54)

Number of Deployments to the Middle East: _____ deployments (55-56)

A 17. Did you work with any casualties or dead on your most recent deployment to the Middle East? (57)

1. Yes
2. No
3. Not Applicable, I have not deployed to the Middle East

If Yes, please describe your experience(s) working with casualties:

(58-60B)

(61-67B)

A 18. Thinking of your most recent Mortuary Affairs work, did you feel:

	Not at All	A little Bit	Moderately	Quite a Bit	Extremely	NA	
a. Frightened.....	0	1	2	3	4	5	(68)
b. Helpless.....	0	1	2	3	4	5	(69)
c. Anxious.....	0	1	2	3	4	5	(70)
d. Horrified.....	0	1	2	3	4	5	(71)
e. Hopeless.....	0	1	2	3	4	5	(72)

A 19. Thinking of your mortuary affairs work, rate your feelings. (Circle the number that best applies for each item):

	<u>Not at All</u>	<u>Somewhat</u>	<u>Moderately</u>	<u>Very Much</u>	<u>Extremely</u>	<u>N/A</u>	
a. It could have been me.....	0	1	2	3	4	5	(73)
b. It could have been my spouse.....	0	1	2	3	4	5	(74)
c. It could have been my son/daughter	0	1	2	3	4	5	(75)
d. It could have been my father/mother.....	0	1	2	3	4	5	(76)
e. One of the victims reminded me of a close friend or relative	0	1	2	3	4	5	(77)
f. Very angry when I thought of the victims ...	0	1	2	3	4	5	(78)

DEPLOYMENT EXPOSURE SCALE

A 20. Did you experience any of the following during your **Deployments** for combat, peacekeeping or disaster?

Consider only deployments that were **2 weeks or longer**. (circle all that apply)

	<u>In the Past 12 months</u>	<u>More Than 1 Year Ago</u>	<u>Never</u>
a. Being in an accident.....	yes	yes	never
b. Being attacked or ambushed.....	yes	yes	never
c. Seeing destroyed homes and villages	yes	yes	never
d. Being shot at	yes	yes	never
e. Seeing dead bodies or body parts.....	yes	yes	never
f. Handling or uncovering dead bodies or body parts	yes	yes	never
g. Smelling a stench of decomposing bodies	yes	yes	never
h. Witnessing an accident which resulted in serious injury or death	yes	yes	never
i. Witnessing violence within the local population or between ethnic groups.....	yes	yes	never
j. Seeing dead or seriously injured Americans.....	yes	yes	never
k. Knowing someone seriously injured or killed	yes	yes	never
l. Having to aid in the removal of unexploded land mines	yes	yes	never
m. Patrolling areas (or riding in areas) where there were land mines	yes	yes	never
n. Having hostile reactions from civilians you were trying to help	yes	yes	never
o. Disarming civilians	yes	yes	never
p. Having contact with traumatized civilians.....	yes	yes	never
q. Having to exercise restraint while patrolling	yes	yes	never
r. Shooting or directing fire at the enemy.....	yes	yes	never
s. Calling in fire on the enemy	yes	yes	never
t. Engaging in hand-to-hand combat.....	yes	yes	never
u. Clearing/searching homes or buildings.....	yes	yes	never
v. Clearing/searching caves	yes	yes	never
w. Questioning detainees/prisoners	yes	yes	never
x. Being wounded	yes	yes	never
y. Seeing children or mothers who were victims of war.....	yes	yes	never
z. Witnessing a suicide bombing	yes	yes	never
aa. Policing or managing civilians in chaotic or unpredictable situations ..	yes	yes	never

A 21. During your **Deployment(s)** in the **past 12 months**, how often did you think you were in danger of being injured or killed?

1. Never
2. Once or twice
3. Sometimes
4. Many times
5. Not Applicable

A 22. Have you ever had an experience that caused you to fear you would be injured or killed (*e.g., serious accident, natural disaster, assault, threatened with a weapon, molested, raped, serious illness, combat*)?

1. NO, never had such an experience
2. YES, only as a child; (*describe*): _____
3. YES, only as an adult; (*describe*): _____
4. YES, BOTH as a child & an adult, (*describe*): _____

(79-104B)

A 23. Are you now preparing to deploy to the Middle East (*Iraq, Afghanistan, Kuwait, and other countries of the region*)? (105)

1. **Yes**, I expect to deploy D / M / Y (*date expect to deploy to the Middle East*) (106-111B)
2. **No**, I am not currently preparing to deploy to the Middle East

PART II. MIDDLE EAST DEPLOYMENT

Have you deployed to the Middle East in the **past 12 months**? Yes ___ No ___ (112)

If **YES**, please complete this section as it relates to your deployment to the Middle East in the **past 12 months**.

If **NO**, Go to Part III.

B 1. Did you work with remains in the Middle East? (113)

1. Yes
2. No

If **Yes**: Total number of **days** you worked with remains in the Middle East: ____ days (114-115)

About **how many** remains did you personally handle: ____ remains (116-117)

B 2. Did you participate in the following while doing MA work in the Middle East?:

- a. Collect remains in the field 1. Yes 2. No 3. NA (118)
- b. Move remains on arrival at mortuary 1. Yes 2. No 3. NA (119)
- c. Identify remains 1. Yes 2. No 3. NA (120)
- d. Put remains in transfer cases 1. Yes 2. No 3. NA (121)
- e. Process personal effects 1. Yes 2. No 3. NA (122)
- f. Administrative work (*not handling remains*) 1. Yes 2. No 3. NA (123)

B 3. Did you have any problems doing your work with remains in the Middle East? (124)

1. Yes
2. No

If **Yes**, please describe: (125-126B)

B. 4. Were you exposed to a **blast** while in the Middle East? 1. Yes 2. No (127)

If **Yes**: a. Were you blown to the ground? 1. Yes (128)
2. No
3. NA (*I was not exposed to a blast*)

b. Did you lose consciousness? 1. Yes for how long: ____ minutes (129)
2. No (130-132)
3. NA (*I was not exposed to a blast*)

B 5. During your deployment to the Middle East how stressful were the following? (Circle the number that best applies for each item).

	Not at All	A little Bit	Moderately	Very	Extremely	N/A	
a. Processing remains.....	0	1	2	3	4	5	(133)
b. Processing personal effects	0	1	2	3	4	5	(134)
c. Being away from home.....	0	1	2	3	4	5	(135)
d. Being away from family.....	0	1	2	3	4	5	(136)
e. Being away from friends	0	1	2	3	4	5	(137)
f. Smallpox vaccination.....	0	1	2	3	4	5	(138)
g. Other inoculations	0	1	2	3	4	5	(139)
h. Finances	0	1	2	3	4	5	(140)
i. Family matters	0	1	2	3	4	5	(141)
j. Safety of family	0	1	2	3	4	5	(142)
k. Concern for a pet	0	1	2	3	4	5	(143)
l. Listening to/watching the news.....	0	1	2	3	4	5	(144)
m. Return home	0	1	2	3	4	5	(145)
n. Other: _____	0	1	2	3	4	5	(146)
							(147-148B)

B 6. What **helped you the most** while you were deployed to the Middle East? (describe below): (149-150B)

B 7. How **rewarding or gratifying** was it for you doing your job during your deployment to the Middle East?
(Circle one number below):

Not at all Rewarding/Gratifying	Slightly Rewarding/Gratifying	Moderately Rewarding/Gratifying	Quite a Bit Rewarding/Gratifying	Extremely Rewarding/Gratifying	
0	1	2	3	4	(151)

B 8. Did anything **positive** come out of your deployment to the Middle East? (152)

1. Yes
2. No

Please describe: (153-154B)

B 9. Did anything **negative** come out of your deployment to the Middle East? (155)

1. Yes
2. No

Please describe: (156-157B)

B 10. What was the **most stressful** part of your deployment to the Middle East? (describe below): (158)

B 11. After returning from deployment, how helpful were each of the following to you?

	<u>Not at All Helpful</u>	<u>Somewhat Helpful</u>	<u>Very Helpful</u>	<u>Not Applicable</u>		
a. Being with family.....	1	2	3	4	5	6 (159)
b. Talking with family	1	2	3	4	5	6 (160)
c. Being with friends	1	2	3	4	5	6 (161)
d. Talking with friends.....	1	2	3	4	5	6 (162)
e. Being with co-workers.....	1	2	3	4	5	6 (163)
f. Talking with co-workers.....	1	2	3	4	5	6 (164)
g. Watching TV coverage of the war.....	1	2	3	4	5	6 (165)
h. Watching other TV shows/movies.....	1	2	3	4	5	6 (166)
i. Keeping to my usual routine.....	1	2	3	4	5	6 (167)
j. Avoiding certain activities.....	1	2	3	4	5	6 (168)
k. Doing things to take my mind off the war ...	1	2	3	4	5	6 (169)
l. Talking to a counselor/therapist.....	1	2	3	4	5	6 (170)
m. Exercise/participation in sports.....	1	2	3	4	5	6 (171)
n. Religious/spiritual activities (<i>prayer meditation, Bible reading</i>).....	1	2	3	4	5	6 (172)
o. Drinking alcohol.....	1	2	3	4	5	6 (173)
p. Being alone	1	2	3	4	5	6 (174)
q. Being with people	1	2	3	4	5	6 (175)
r. Activities online (computer).....	1	2	3	4	5	6 (176)
s. Leisure or restful/relaxing activities	1	2	3	4	5	6 (177)
t. Other _____	1	2	3	4	5	6 (178)

B 12. Since your deployment to the Middle East, have you had a **close friend or buddy who supported you?** (179)

1. Yes
2. No

If Yes, please describe what they did to support you:

(180-181B)

B 13. Since your deployment to the Middle East, have you provided support to anyone? (182)

1. Yes
2. No

If Yes, please describe what you did to support them:

(183-184B)

B 14. Did you receive readjustment briefings in the Middle East **before returning home?** (185)

1. Yes
2. No

If Yes, how **helpful** were the briefings (*circle one number below*):

Not at all	Slightly	Moderately	Quite a Bit	Extremely	
0	1	2	3	4	(186)

- B 15. Since returning home have you received readjustment briefings? (187)
1. Yes
 2. No

If Yes, how **helpful** were the briefings (*circle one number below*):

Not at all	Slightly	Moderately	Quite a Bit	Extremely	
0	1	2	3	4	(188)

- B 16. Since your return from deployment to the Middle East, was there anything that **would have been helpful** (189) **that wasn't done?**
1. Yes
 2. No

If Yes, please describe what would have been helpful:

(190-200B)

- B 17. Since your return from deployment to the Middle East, how long did it take you to return to your normal activities and pace of life? (201)
1. Less than 1 week
 2. 1-2 weeks
 3. 1 month
 4. 2-3 months
 5. Still not back to normal pace of life
 6. NA, there was no change in my normal activities and pace of life

(202-212B)

PART III. PREPARING FOR FUTURE DEPLOYMENTS

- C 1. Thinking of deployment, how concerned are you about the following?

	Not at All Concerned	Moderately Concerned	Extremely Concerned	Not Applicable			
a. Physical injury	1	2	3	4	5	6	(213)
b. Death of self	1	2	3	4	5	6	(214)
c. Death of a friend or buddy.....	1	2	3	4	5	6	(215)
d. Spouse/Significant Other back home.....	1	2	3	4	5	6	(216)
e. My child(ren)	1	2	3	4	5	6	(217)
f. My SSO being unfaithful to me	1	2	3	4	5	6	(218)
g. Me being unfaithful to my SSO.....	1	2	3	4	5	6	(219)
h. Other: _____	1	2	3	4	5	6	(220)

(221-222B)

- C 2. How helpful are the following activities in preparing for deployment? (*Circle the number that best applies for each item*):

	Not at All	A little Bit	Moderately	Very	Extremely	N/A	
a. Talking to friends/family	0	1	2	3	4	5	(223)
b. Watching the News.....	0	1	2	3	4	5	(224)
c. Prior Deployment(s)	0	1	2	3	4	5	(225)
d. Other: _____	0	1	2	3	4	5	(226)

(227-228B)

C 3. How **helpful** are each of the following sources of information for preparing for upcoming events & deployments?

	<u>Not at All Helpful</u>	<u>Somewhat Helpful</u>	<u>Very Helpful</u>	<u>Not Applicable</u>		
a. Unit Newsletter	1	2	3	4	5	6 (229)
b. Unit Briefings	1	2	3	4	5	6 (230)
c. Chain of Command	1	2	3	4	5	6 (231)
d. Word-of-Mouth.....	1	2	3	4	5	6 (232)
e. Unit Members	1	2	3	4	5	6 (233)
f. Civilian Newspapers.....	1	2	3	4	5	6 (234)
g. Installation Newspaper.....	1	2	3	4	5	6 (235)
h. Television	1	2	3	4	5	6 (236)
i. Internet	1	2	3	4	5	6 (237)
j. Other _____	1	2	3	4	5	6 (238)

C 4. If you are currently preparing for deploying how **stressful** are the following activities? (*Circle the number that best applies for each item*). If you are **NOT** currently preparing for deployment circle 5. N/A:

	<u>Not at All</u>	<u>A little Bit</u>	<u>Moderately</u>	<u>Very</u>	<u>Extremely</u>	<u>N/A</u>	
a. Fear of Smallpox Vaccine	0	1	2	3	4	5	(239)
b. Fear of other inoculations.....	0	1	2	3	4	5	(240)
c. Getting finances in order.....	0	1	2	3	4	5	(241)
d. Settling family matters	0	1	2	3	4	5	(242)
e. Worry about family	0	1	2	3	4	5	(243)
f. Worry about safety of family	0	1	2	3	4	5	(244)
g. Settling work matters	0	1	2	3	4	5	(245)
h. Concern for a pet.....	0	1	2	3	4	5	(246)
i. Watching the News	0	1	2	3	4	5	(247)
j. Other: _____..	0	1	2	3	4	5	(248)

(249-250B)

PART IV. PRESENT EXPERIENCE

D 1. Using the scale below, for each item circle the number that best describes you at the **present time**.

	<u>Very Low</u>	<u>Low</u>	<u>Medium</u>	<u>High</u>	<u>Very High</u>	
a. Your personal morale.....	1	2	3	4	5	(251)
b. Your level of motivation.....	1	2	3	4	5	(252)
c. Your level of energy.	1	2	3	4	5	(253)
d. Your level of drive.....	1	2	3	4	5	(254)

D 2. Using the scale below, circle one number per item that best describes your Unit at the **present time**.

	<u>Strongly Disagree</u>	<u>Disagree</u>	<u>Neutral</u>	<u>Agree</u>	<u>Strongly Agree</u>	
a. The members of my unit are cooperative with each other.....	1	2	3	4	5	(255)
b. The members of my unit know they can depend on each other.....	1	2	3	4	5	(256)
c. The members of my unit stand up for each other.	1	2	3	4	5	(257)
d. The leaders of this company would lead well in combat.....	1	2	3	4	5	(258)
e. I am impressed by the quality of leadership in this company.....	1	2	3	4	5	(259)
f. My chain of command works well.....	1	2	3	4	5	(260)

D 3. What kind of **problems** have you encountered during the past 3 months?:

- | | | | | |
|--------------------------------------|--------|-------|-------|-----------|
| a. Unit problems | 1. Yes | 2. No | 3. NA | (261) |
| b Marital problems..... | 1. Yes | 2. No | 3. NA | (262) |
| c Personal problems..... | 1. Yes | 2. No | 3. NA | (263) |
| d Problems with child(ren) | 1. Yes | 2. No | 3. NA | (264) |
| e. Religious/spiritual problems..... | 1. Yes | 2. No | 3. NA | (265) |
| f. Problems with parents | 1. Yes | 2. No | 3. NA | (266) |
| g. In-law problems..... | 1. Yes | 2. No | 3. NA | (267) |
| h. Financial problems..... | 1. Yes | 2. No | 3. NA | (268) |
| i. Medical problems | 1. Yes | 2. No | 3. NA | (269) |
| j. Other _____ | 1. Yes | 2. No | 3. NA | (270-271) |

Please Describe the Problems:

(272-273B)
(274-294B)

D 4. Using the scale below indicate how strongly you agree or disagree with each of the following items.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
a. I am deploying more than expected	1	2	3	4	5	6 (295)
b. The frequency of deployment is too intense	1	2	3	4	5	6 (296)
c. The deployments are too long.....	1	2	3	4	5	6 (297)
d. Uncertainty about deployments is difficult.....	1	2	3	4	5	6 (298)
e. The deployments have made my work more interesting	1	2	3	4	5	6 (299)
f. Deployments give me a chance to use my skills	1	2	3	4	5	6 (300)
g. Deployments show me how important my job is	1	2	3	4	5	6 (301)
h. I wouldn't mind the deployments if there weren't so many	1	2	3	4	5	6 (302)
i. Number of deployments has put a big strain on my family	1	2	3	4	5	6 (303)
j. Number of deployments has hurt the stability of my marriage.....	1	2	3	4	5	6 (304)
k. I am planning to get out of the military because there are too many deployments	1	2	3	4	5	6 (305)

D 5. Using the scale below, for each item circle the number that best describes you at the **Present Time**.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Not Applicable
	1	2	3	4	5	6
a. The demands of work interfere with my home and family life	1	2	3	4	5	6 (306)
b. The amount of time my job takes up makes it difficult to fulfill family responsibilities.....	1	2	3	4	5	6 (307)
c. Things I want to do at home do not get done because of the demands my job puts on me.....	1	2	3	4	5	6 (308)
d. My job produces strain that makes it difficult to fulfill family duties.....	1	2	3	4	5	6 (309)
e. Due to work-related duties, I have to make changes to my plans for family activities	1	2	3	4	5	6 (310)
f. The demands of my family or significant other interfere with work-related activities	1	2	3	4	5	6 (311)
g. I have to put off doing things at work because of family demands.....	1	2	3	4	5	6 (312)
h. Things I want to do at work don't get done because of demands of my family or significant other	1	2	3	4	5	6 (313)
i. My home life interferes with my responsibilities at work such as getting to work on time, accomplishing daily tasks and working overtime.....	1	2	3	4	5	6 (314)
j. Family-related strain interferes with my ability to perform job-related duties	1	2	3	4	5	6 (315)

D 6. Rate the current **degree of support or lack of support** – emotional and practical – you feel from each of the following individuals:

	<u>None</u>	<u>Moderate</u>		<u>A Great Deal</u>	<u>Not Applicable</u>		
a. Family.....	0	1	2	3	4	(316)	
b. Friends.....	0	1	2	3	4	5	(317)
c. Co-Workers	0	1	2	3	4	5	(318)
d. Supervisors.....	0	1	2	3	4	5	(319)

SN

D 7. How many close friends do you have? (*People you feel at ease with, & can talk to about private matters, & can call on for help*) (320)

- 1. None
- 2. 1 - 2
- 3. 3 - 5
- 4. 6 - 9
- 5. 10 or more

D 8. How many relatives do you have that you feel close to? (321)

- 1. None
- 2. 1 - 2
- 3. 3 - 5
- 4. 6 - 9
- 5. 10 or more

D 9. How many of these friends or relatives do you see at least once a month? (322)

- 1. None
- 2. 1 - 2
- 3. 3 - 5
- 4. 6 - 9
- 5. 10 or more

D 10. During the last two months were you active in any of the following kinds of groups?

- | | | | |
|--|--------|-------|-------|
| a. A social or recreational group? | 1. Yes | 2. No | (323) |
| b. A labor union, commercial group, or professional organization?..... | 1. Yes | 2. No | (324) |
| c. A church group?..... | 1. Yes | 2. No | (325) |
| d. A group concerned with children? | 1. Yes | 2. No | (326) |
| e. A group concerned with community betterment, charity or service | 1. Yes | 2. No | (327) |
| f. Any other group? | 1. Yes | 2. No | (328) |
- (329-330B)
(331-351B)

D 11. Are you currently living with a Spouse or Significant Other (SSO) (*not including children or parents*) ? (352)

1. Yes (if yes, continue answering the questions below)

2. No (if no, skip to the PART V. HEALTH & STRESS)

COUPLES' (SPOUSE/SIGNIFICANT OTHERS) RELATIONSHIP

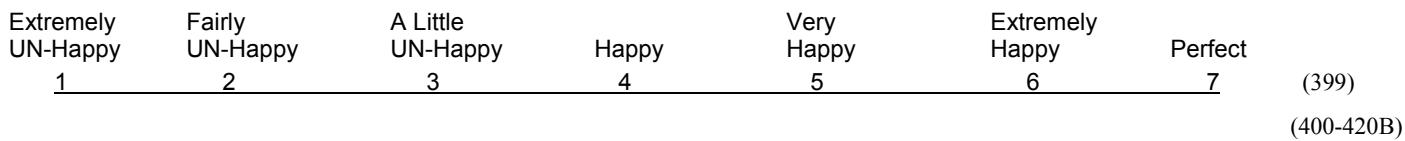
Couples, Spouse/Significant Others (SSOs), use many ways of trying to settle their differences. The following is a list of some things that you & your spouse/significant other (partner) might have done when you had a dispute. Thinking over your relationship, indicate whether you have experienced any of the events below by placing an "X" on the line if the event occurred in the **past 3 months**.

PAST 3 MONTHS

1. A Have you gotten information to back up your side of things (353)
B Has your spouse (or partner) gotten information (354)
2. A Have you tried to bring in someone to help settle things (355)
B Has your spouse or partner (356)
3. A Have you refused to give affection or sex to spouse (357)
B Has your spouse or partner (358)
4. A Have you insulted or sworn at your spouse (359)
B Has your spouse or partner (360)
5. A Have you sulked and/or refused to talk (during a conflict) (361)
B Has your spouse or partner (362)
6. A Have you stomped out of the room, house or yard (363)
B Has your spouse or partner (364)
7. A Have you cried (during a conflict) (365)
B Has your spouse or partner (366)
8. A Have you done or said something to spite spouse (367)
B Has your spouse or partner (368)
9. A Have you threatened to leave the marriage (369)
B Has your spouse or partner (370)
10. A Have you threatened to do things like take money, have an affair, etc. (371)
B Has your spouse or partner (372)
11. A Have you tried to control your spouse physically (held down, etc.) (373)
B Has your spouse or partner (374)
12. A Have you threatened to hit or throw something at your spouse (375)
B Has your spouse or partner (376)
13. A Have you thrown, smashed, hit, or kicked something (377)
B Has your spouse or partner (378)
14. A Have you driven recklessly to frighten your spouse (379)
B Has your spouse or partner (380)
15. A Have you thrown something at your spouse (381)
B Has your spouse or partner (382)
16. A Have you pushed, grabbed, or shoved your spouse (383)
B Has your spouse or partner (384)
17. A Have you slapped your spouse (385)
B Has your spouse or partner (386)

PAST 3 MONTHS

18. A Have you kicked, bit or hit your spouse with a fist..... _____ (387)
 B Has your spouse or partner _____ (388)
19. A Have you choked or strangled your spouse _____ (389)
 B Has your spouse or partner _____ (390)
20. A Have you physically forced spouse to have sex..... _____ (391)
 B Has your spouse or partner _____ (392)
21. A Have you beat up your spouse _____ (393)
 B Has your spouse or partner _____ (394)
22. A Have you threatened your spouse with a knife or gun _____ (395)
 B Has your spouse or partner _____ (396)
23. A Have you used a knife or gun on your spouse _____ (397)
 B Has your spouse or partner _____ (398)
24. The numbers on the line below represent different degrees of happiness couples, Spouse/Significant Others (SSOs), experience in their relationship. Circle the number directly on the scale below which best describes your degree of happiness, all things considered, in your relationship with your SSO:



PART V. HEALTH & STRESS

- E 1. Rate the degree of stress each of the following individuals are experiencing **currently**:

<u>CURRENT STRESS:</u>	<u>None</u>	<u>Moderate</u>	<u>A Great Deal</u>	<u>Not Applicable</u>	
a. You, yourself	0	1	2	3	4 (421)
b. Your spouse/significant other	0	1	2	3	4 (422)
c. Your children	0	1	2	3	4 (423)

(424-434B)

- E 2. Have you obtained any **medical care** during the past 6 months?
- a. Annual physical 1. Yes 2. No (435)
 - b. For physical problems 1. Yes 2. No (436)
 - c. For emotional or family problems 1. Yes 2. No (437)
 - d. Have you felt in need of medical care, but have not obtained any? 1. Yes 2. No (438)
- E 3. **In the past month**, how many workdays have you missed due to illness? ____ (439-440)
- E 4. **In the past month**, how many times have you seen a health care provider? ____ (441-442)
- E 5. **In the past year** have you felt any of the following: (*circle "1. Yes" or "2. No" for each item*):
- a. You needed to cut back on your alcohol drinking 1. Yes 2. No (443)
 - b. Annoyed at anyone who suggested you cut back on your drinking 1. Yes 2. No (444)
 - c. You needed an "eye-opener" or early morning drink 1. Yes 2. No (445)
 - d. Guilty about your drinking 1. Yes 2. No (446)
 - e. You used alcohol more than you meant to 1. Yes 2. No (447)

E 6. In the past **3 months** did you change your **drinking habits for any 2 week period of time or more?** (448)

1. I do not drink alcohol
2. The amount I drank remained the **same**
3. I drank **more** than usual
4. I drank **less** than usual
5. I had stopped drinking but started again

E 7. In the past **3 months** did you change any **tobacco habits** (*cigarettes, pipe, cigars, chewing tobacco*) **for any 2 week period of time or more??** (449)

1. I do not use tobacco
2. My tobacco use remained the **same**
3. I **increased** my use of tobacco
4. I **decreased** my use of tobacco
5. I had stopped using tobacco but started using it again

E 8. In the **past 3 months**, how much have you been bothered by emotional problems (such as feeling anxious, depressed or irritable)?

Not at all 0	Slightly 1	Moderately 2	Quite a Bit 3	Extremely 4	(450)
-----------------	---------------	-----------------	------------------	----------------	-------

E 9. In the **past 3 months**, how much did personal or emotional problems keep you from doing your usual work, studies, or other daily activities?

Not at all 0	Very Little 1	Somewhat 2	Quite a Bit 3	Could not do Daily Activities 4	(451)
-----------------	------------------	---------------	------------------	---------------------------------------	-------

E 10. Over the **past two weeks** how often, on average, did you experience the following when at work:

	None of the Time	Some of the Time	Half of the Time	Most of the Time	All of the Time	
a. Lose concentration.....	1	2	3	4	5	(452)
b. Repeat a job.....	1	2	3	4	5	(453)
c. Work more slowly than usual.....	1	2	3	4	5	(454)
d. Felt fatigued.....	1	2	3	4	5	(455)
e. Did nothing at work.....	1	2	3	4	5	(456)
						(457-477B)

E 11. Would you say your general health is:

Excellent 1	Very Good 2	Good 3	Fair 4	Poor 5	(478)
----------------	----------------	-----------	-----------	-----------	-------

E 12. Now thinking about your **physical health**, which includes physical illness and injury, for how many days during the **past 30 days** was your physical health not good (*if the answer is none, put 00*).

_____ number of days (479-480)

E 13. Now thinking about your **mental health** which includes stress, depression and problems with emotions, for how many days during the **past 30 days** was your mental health not good? (*if the answer is none, put 00*)

_____ number of days (481-482)

- E 14. During the **past 30 days**, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work or recreation? (*if the answer is none, put 00*)

____ number of days

(483-484)

- E 15. During the **past 30 days**, for about how many days did poor physical or mental health keep you from going to work? (*if the answer is none, put 00*)

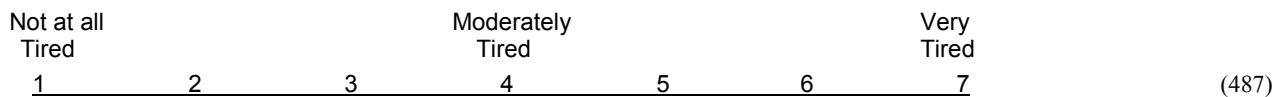
____ number of days

(485-486)

PHYSICAL HEALTH PRACTICES

The questions below are about your current activities & habits. Fill in or circle the number that best applies.

- E 16. During the past week, how fatigued (tired, "pooped") did you feel? (*Circle the number of the scale below.*)



- E 17. Approximately how many hours of sleep did you get over the **past week** on each of these nights?

Sunday	__ __	hours	(488-489)
Monday	__ __	hours	(490-491)
Tuesday	__ __	hours	(492-493)
Wednesday	__ __	hours	(494-495)
Thursday	__ __	hours	(496-497)
Friday	__ __	hours	(498-499)
Saturday	__ __	hours	(500-501)

- E 18. How many cigarettes do you smoke per day? (*Number of cigarettes, not packs.*)

- | | | |
|------------------------------------|-------------------------------------|-------|
| 1. I have never smoked cigarettes. | 5. 11 - 15 cigarettes per day. | (502) |
| 2. I quit smoking cigarettes. | 6. 16 - 20 cigarettes per day. | |
| 3. 1 - 5 cigarettes per day. | 7. More than 20 cigarettes per day. | |
| 4. 6 - 10 cigarettes per day. | | |

- E 19. How often do you drink alcoholic beverages?

- | | | |
|--------------------------------------|--------------------------|-----------|
| 1. Never | 6. Once a week | (503-504) |
| 2. Less than once every 2 - 3 months | 7. 2 or 3 times per week | |
| 3. Once every 2 or 3 months | 8. 4 or 5 times per week | |
| 4. About once per month | 9. Almost every day | |
| 5. About every 2 or 3 weeks | 10. Every day | |

- E 20. How many alcoholic drinks (*one 12 oz. beer, one glass of wine, or one cocktail*) do you usually consume at one time?

- | | |
|------------------------------------|-------|
| 1. Never drink alcoholic beverages | (505) |
| 2. 1 drink | |
| 3. 2 drinks | |
| 4. 3-4 drinks | |
| 5. 5-6 drinks | |
| 6. 7-8 drinks | |
| 7. More than 8 drinks | |

MFQ

E 21. Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is **True** or **False** as it describes you. Circle 1. **True** if the item describes you. Circle 2. **False** if the item does not describe you.

- | | | | |
|--|---------|----------|-------|
| 1. I could not remove the hook from a fish that was caught | 1. True | 2. False | (506) |
| 2. I would feel some revulsion looking at a preserved brain in a bottle..... | 1. True | 2. False | (507) |
| 3. If a badly injured person appears on TV, I turn my head away | 1. True | 2. False | (508) |
| 4. I dislike looking at pictures of accidents or injuries in magazines | 1. True | 2. False | (509) |
| 5. I do not mind visiting a hospital and seeing ill or injured persons | 1. True | 2. False | (510) |
| 6. Medical odors make me tense and uncomfortable | 1. True | 2. False | (511) |
| 7. I would not go hunting because I could not stand the sight of a dead animal | 1. True | 2. False | (512) |
| 8. Watching a butcher at work would make me anxious | 1. True | 2. False | (513) |
| 9. A career as a doctor or nurse is very attractive to me | 1. True | 2. False | (514) |
| 10. I would feel faint if I saw someone with a wound in the eye | 1. True | 2. False | (515) |
| 11. Watching people use sharp power tools makes me nervous | 1. True | 2. False | (516) |
| 12. The prospect of getting an injection or seeing someone else get one
bothers me quite a bit | 1. True | 2. False | (517) |
| 13. I feel sick or faint at the sight of blood | 1. True | 2. False | (518) |
| 14. I enjoy reading articles about modern medical techniques | 1. True | 2. False | (519) |
| 15. Injuries, accidents, blood, etc., bother me more than anything else | 1. True | 2. False | (520) |
| 16. Under no circumstances would I accept an invitation to watch a
surgical operation | 1. True | 2. False | (521) |
| 17. When I see an accident I feel tense | 1. True | 2. False | (522) |
| 18. It would not bother me to see a bad cut as long as it had been cleaned
and stitched | 1. True | 2. False | (523) |
| 19. Using very sharp knives makes me nervous..... | 1. True | 2. False | (524) |
| 20. Not only do cuts and wounds upset me, but the sight of people with
amputated limbs, large scars, or plastic surgery also bothers me | 1. True | 2. False | (525) |
| 21. If instruments were available, it would be interesting to see
the action of the internal organs in a living body | 1. True | 2. False | (526) |
| 22. I am frightened at the idea of someone drawing a blood sample from me | 1. True | 2. False | (527) |
| 23. I don't believe anyone could help a person with a bloody wound
without feeling at least a little upset | 1. True | 2. False | (528) |
| 24. I am terrified by the idea of having surgery | 1. True | 2. False | (529) |
| 25. I am frightened by the thought that I might some day have to help
a person badly hurt in a car wreck | 1. True | 2. False | (530) |
| 26. I shudder when I think of accidentally cutting myself..... | 1. True | 2. False | (531) |
| 27. The sight of dried blood is repulsive | 1. True | 2. False | (532) |
| 28. Blood and gore upset me no more than the average person | 1. True | 2. False | (533) |
| 29. The sight of an open wound nauseates me | 1. True | 2. False | (534) |
| 30. I could never swab out a wound | 1. True | 2. False | (535) |

(536-556B)

PCL-17

- E 22. Below is a list of reactions that soldiers sometimes experience following deployment or in response to other stressful life experiences. Please mark how much you have been bothered by each problem in the past month.

	<u>Not at All</u>	<u>A Little Bit</u>	<u>Moderately</u>	<u>Quite a Bit</u>	<u>A lot</u>	
1. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past.....	1	2	3	4	5	(557)
2. Repeated, disturbing dreams of a stressful experience from the past.....	1	2	3	4	5	(558)
3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)	1	2	3	4	5	(559)
4. Feeling very upset when something reminded you of a stressful experience from the past	1	2	3	4	5	(560)
5. Having physical reactions (like heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past	1	2	3	4	5	(561)
6. Avoiding thinking about or talking about a stressful experience from the past or avoiding having feelings related to it.....	1	2	3	4	5	(562)
7. Avoiding activities or situations because they reminded you of a stressful experience from the past.....	1	2	3	4	5	(563)
8. Trouble remembering important parts of a stressful experience from the past	1	2	3	4	5	(564)
9. Loss of interest in activities that you used to enjoy	1	2	3	4	5	(565)
10. Feeling distant or cut off from other people	1	2	3	4	5	(566)
11. Feeling emotionally numb or being unable to have loving feelings for those close to you.....	1	2	3	4	5	(567)
12. Feeling as if your future will somehow be cut short	1	2	3	4	5	(568)
13. Trouble falling or staying asleep	1	2	3	4	5	(569)
14. Feeling irritable or having angry outbursts.....	1	2	3	4	5	(570)
15. Having difficulty concentrating.....	1	2	3	4	5	(571)
16. Being super alert" or watchful or on-guard	1	2	3	4	5	(572)
17. Feeling jumpy or easily startled	1	2	3	4	5	(573)

- E 23. What was the **most stressful experience in your life** that you think may have triggered the above symptoms? (574)

1. Experience during the most recent deployment
2. Experience during prior deployment
3. Other stressful experience in military: _____ (*describe experience*)
4. Other stressful life experience prior to military: _____ (*describe experience*)

(575-580B)

- E 24. Thinking of the **stressful life experience above**, to what extent did you feel:

	<u>Not at All</u>	<u>A little Bit</u>	<u>Moderately</u>	<u>Quite a Bit</u>	<u>Extremely</u>	
a. Frightened.....	0	1	2	3	4	(581)
b. Helpless	0	1	2	3	4	(582)
c. Anxious.....	0	1	2	3	4	(583)
d. Horrified	0	1	2	3	4	(584)
e. Hopeless.....	0	1	2	3	4	(585)

PHQ

E 25. Over the Last Two Weeks, how often have you been bothered by any of the following problems?

	Not at All	Several Days	More than Half the Days	Nearly Every Day	
1. Little interest or pleasure in doing things.....	1	2	3	4	(586)
2. Feeling down, depressed, or hopeless.....	1	2	3	4	(587)
3. Trouble falling or staying asleep, or sleeping too much	1	2	3	4	(588)
4. Feeling tired or having little energy	1	2	3	4	(589)
5. Poor appetite or overeating	1	2	3	4	(590)
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down.....	1	2	3	4	(591)
7. Trouble concentrating on things, such as reading the newspaper or watching television.....	1	2	3	4	(592)
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been Moving around a lot more than usual	1	2	3	4	(593)
9. Thoughts that you would be better off dead or of hurting yourself in some way.	1	2	3	4	(594)

ID Scale

E 26. The following statements inquire about your thoughts and feelings in a variety of situations. Using the scale below, please **circle** the number to the right that indicates **how well each item describes you**.

		<u>Does Not Describe Me Well</u>					<u>Describes Me Very Well</u>		
I	1. I daydream and fantasize, with some regularity, about things that might happen to me	1	2	3	4	5			(595)
I	2. I often have tender, concerned feelings for people less fortunate than me	1	2	3	4	5			(596)
I	3. I am usually objective when I watch a movie or play, and I don't often get completely caught up in it	1	2	3	4	5			(597)
I	4. When I see someone being taken advantage of, I feel kind of protective towards them	1	2	3	4	5			(598)
I	5. I sometimes feel helpless when I am in the middle of a very emotional situation.	1	2	3	4	5			(599)
I	6. Other people's misfortunes do not usually disturb me a great deal.....	1	2	3	4	5			(600)
I	7. After seeing a play or movie, I have felt as though I were one of the characters	1	2	3	4	5			(601)
I	8. Being in tense emotional situations scares me.....	1	2	3	4	5			(602)
I	9. I am often quite touched by things that I see happen.....	1	2	3	4	5			(603)
I	10. I would describe myself as a pretty soft-hearted person.....	1	2	3	4	5			(604)
I	11. When I am reading an interesting story or novel, I imagine how I would feel if the events in the story were happening to me	1	2	3	4	5			(605)
I	12. When I see someone who badly needs help in an emergency, I go to pieces	1	2	3	4	5			(606)
M	13. If a badly injured person appears on TV, I turn my head away	1	2	3	4	5			(607)
M	14. I do not mind visiting a hospital and seeing ill or injured persons.....	1	2	3	4	5			(608)
M	15. A career as a doctor or nurse is very attractive to me	1	2	3	4	5			(609)
M	16. Under no circumstances would I accept an invitation to watch a surgical operation	1	2	3	4	5			(610)
M	17. When I see an accident I feel tense.....	1	2	3	4	5			(611)
M	18. I don't believe anyone could help a person with a bloody wound without feeling at least a little upset.....	1	2	3	4	5			(612)

							<u>Does Not Describe Me Well</u>	<u>Describes Me Very Well</u>	
M	19.	Blood and gore upset me no more than the average person.....	1	2	3	4	5		(613)
M	20.	I could never swab out a wound	1	2	3	4	5		(614)
N	21.	Before voting I thoroughly investigate the qualifications of all the candidates ..	1	2	3	4	5		(615)
N	22.	I never hesitate to go out of my way to help someone in trouble	1	2	3	4	5		(616)
N	23.	It is sometimes hard for me to go on with my work if I am not encouraged	1	2	3	4	5		(617)
N	24.	On occasion I have had doubts about my ability to succeed in life	1	2	3	4	5		(618)
N	25.	I sometimes feel resentful when I do not get my way.....	1	2	3	4	5		(619)
N	26.	I am always careful about my manner of dress.....	1	2	3	4	5		(620)
N	27.	My table manners at home are as good as when I eat out in a restaurant	1	2	3	4	5		(621)
N	28.	On a few occasions, I have given up doing something because I thought too little of my ability.....	1	2	3	4	5		(622)
N	29.	I like to gossip at times	1	2	3	4	5		(623)
N	30.	There have been times when I felt like rebelling against people in authority even though I knew they were right	1	2	3	4	5		(624)
N	31.	No matter who I'm talking to, I'm always a good listener.....	1	2	3	4	5		(625)
N	32.	There have been occasions when I took advantage of someone	1	2	3	4	5		(626)
N	33.	I always try to practice what I preach.....	1	2	3	4	5		(627)
N	34.	I sometimes try to get even, rather than forgive and forget	1	2	3	4	5		(628)
N	35.	When I don't know something I don't at all mind admitting it.....	1	2	3	4	5		(629)
N	36.	At times I have really insisted on having things my own way.....	1	2	3	4	5		(630)
N	37.	I never make a long trip without checking the safety of my car	1	2	3	4	5		(631)
N	38.	I have never felt that I was punished without cause.....	1	2	3	4	5		(632)
N	39.	I sometimes think when people have a misfortune they only got what they deserved.....	1	2	3	4	5		(633)
N	40.	I have never deliberately said something that hurt someone's feelings.....	1	2	3	4	5		(634)
I	41.	I sometimes find it difficult to see things from the "other guy's" point of view	1	2	3	4	5		(635)
I	42.	When I see someone get hurt, I tend to remain calm	1	2	3	4	5		(636)
I	43.	Before criticizing somebody, I try to imagine how I would feel if I were in their place.....	1	2	3	4	5		(637)
M	44.	I would not go hunting because I could not stand the sight of a dead animal....	1	2	3	4	5		(638)
M	45.	I am frightened by the thought that I might some day have to help a person badly hurt in a car wreck	1	2	3	4	5		(639)
N	46.	On occasion I have had doubts about my ability to succeed in life	1	2	3	4	5		(640)



IF YOU HAVE ADDITIONAL COMMENTS or IDEAS YOU WOULD LIKE to SHARE WITH US, PLEASE USE the
SPACE BELOW & THE BACK OF THIS PAGE:

(641B)
(642-652B)

E2. Intervention Group Month 2 Questionnaire

Questionnaire
Mortuary Affairs Soldiers
Troop Education for Army Morale (TEAM)
(Intervention Version)

Please Return to:

Carol S. Fullerton, Ph.D.
Department of Psychiatry
Uniformed Services University of the Health Sciences
4301 Jones Bridge Road
Bethesda, Maryland 20814-4799

Version 3.0
30 July 2009
Workshop 1

Mortuary Affairs Soldiers: Early Intervention and Altering Barriers to Care

Uniformed Services University, Bethesda, MD

Mortuary Affairs Questionnaire

INSTRUCTIONS

During the past several years Army Mortuary Affairs soldiers have had many operational deployments. Preparing for deployments, the actual deployment, and return present many challenges for soldiers, families, units and communities. You have volunteered to participate in a program, the Post Deployment Program (PDP), to help with your return to post-deployment life and learn new skills that will be helpful at other times. Many of you who are participating in the PDP have taken a larger questionnaire in the past.

The purpose of this questionnaire you are taking today is to learn more about how you are feeling and what you have learned from our program. This questionnaire has many of the same questions you have seen before, but we need to understand what has changed for you since the last time you took it. Therefore, your responses are especially important to us to better prepare MA soldiers for return from future deployments.

There is no right or wrong answer to any of the questions. Just answer the questions the way you feel and write in whatever you want to where you are asked to provide a description or response. You do not have to answer any questions that make you feel uncomfortable, however, by not responding to all the questions limits what we can use from your questionnaire. You may discontinue participation in this study at any time.

ADDITIONAL INFORMATION

We need to use the information you have given us in previous questionnaires and for future questionnaires. In order to do that, we need to use the code that you used before. This is necessary order to be able to match this questionnaire with all others you have taken in the past and in the future. We still will not identify you as an individual or report on your individual responses. This code is a unique combination of letters and numbers that allows us to use your information without identifying you personally.

1. **Last letter** of your mother's maiden name: _____ (e.g., for "Smith" put "h")
2. **First letter** of the city you were born in: _____ (e.g., for "Baltimore" put "B")
3. **First letter** of the month you were born: _____ (e.g., for "July" put "J")
4. **Last digit** of the **day of the month** you were born: _____ (e.g., for "06 July" put "6"; or for "12 July" put "2")
5. **Last digit** of the **year** you were born: _____ (e.g., for "1976" put "6")

Print Name: _____

Address: _____

Phone: _____ Email: _____

Cell Phone: _____

PART I. BACKGROUND INFORMATION

Please answer the questions below by filling in the blanks or circling the number of the response that best applies.

A 1. Today's Date: / / / / /

A 2. Your Age: ____ years

A 3. Your Sex: 1. Male 2. Female

A 4. Your Pay Grade (*e.g., E-5*): ____ - ____

A 5. Your Company: _____ MOS: _____

A 6. Highest level of education you have completed:

1. Less than 12th grade
2. High School or G.E.D.
3. Some College/Technical school
4. Bachelor's Degree
5. Graduate Degree (Masters or doctoral)

A 7. Racial/Ethnic Background:

1. American Indian or Alaskan Native
2. Asian or Pacific Islander
3. Black, not of Hispanic origin
4. Hispanic
5. White, not of Hispanic origin.

A 8. Are you currently married?

1. Yes If yes, number of years: _____
2. No

A 9. Do you currently live with your Spouse?

1. Yes
2. No
3. Not Applicable (*not married*)

A 10. Do you currently live with a Significant Other (*not including spouse, parents or children*)?

1. Yes, number of years: ____
2. No

PART II. MIDDLE EAST DEPLOYMENT

B 1. What was the **most stressful** part of your deployment to the Middle East? (*Please describe below*)

B 2. What has been the **most stressful** for you since your **return**. (*Please describe below*)

B 3. During your **deployment**, how often did you think you were in danger of being injured or killed?

1. Never
2. Once or twice
3. A number of times
4. Many times.

B 4. Did you work with any casualties or dead on your most recent deployment to the Middle East?

1. Yes
2. No
3. Not Applicable, I have not deployed to the Middle East

If Yes, *please describe your experience(s) working with casualties:*

PART III. PRESENT EXPERIENCE

C 1. Using the scale below, for each item circle the number that best describes **you at the present time**.

	<u>Very Low</u>	<u>Medium</u>	<u>Very High</u>
a. Your personal morale.....	1	2	3
b. Your level of motivation.....	1	2	3
c. Your level of energy.....	1	2	3
d. Your level of drive.....	1	2	4
			5

C 2. Using the scale below, circle one number per item that best describes **your Unit at the present time**.

	<u>Strongly Disagree</u>	<u>Neutral</u>	<u>Strongly Agree</u>
a. The members of my unit are cooperative with each other.....	1	2	3
b. The members of my unit know they can depend on each other	1	2	3
c. The members of my unit stand up for each other	1	2	3
d. The leaders of this company would lead well in combat.....	1	2	4
e. I am impressed by the quality of leadership in this company.....	1	2	4
f. My chain of command works well.....	1	2	4
			5

C 3. What kind of **problems** have you encountered during the past **MONTH**?

- a. Unit problems..... 1. Yes 2. No 3. NA
- b. Marital problems 1. Yes 2. No 3. NA
- c. Personal problems 1. Yes 2. No 3. NA
- d. Problems with child(ren)..... 1. Yes 2. No 3. NA
- e. Religious/spiritual problems..... 1. Yes 2. No 3. NA
- f. Problems with parents..... 1. Yes 2. No 3. NA
- g. In-law problems 1. Yes 2. No 3. NA
- h. Financial problems 1. Yes 2. No 3. NA
- i. Medical problems..... 1. Yes 2. No 3. NA
- j. Other _____ 1. Yes 2. No 3. NA

If yes, **Please Describe the Problems:**

C 4. Current legal and medical issues. Please circle your response to each of the following items.

- a. Are you currently undergoing a medical board? 1. Yes 2. No 3. Don't know
- b. Are you currently being processed for an administrative discharge? 1. Yes 2. No 3. Don't know
- c. Are you currently being processed for any other UCMJ action 1. Yes 2. No 3. Don't know
(such as a court martial)?

If yes, **Please Describe the Problems:**

C 5. Rate the current **degree of support or lack of support** – emotional and practical – you feel from each of the following individuals:

	<u>None</u>	<u>Moderate</u>	<u>A Great Deal</u>	<u>Not Applicable</u>
a. Family	0	1	2	3
b. Friends	0	1	2	3
c. Co-Workers	0	1	2	3
d. Supervisors.....	0	1	2	4

C 6. Below are questions about how safe you have been feeling:

	<u>Not at All</u>	<u>A Little Bit</u>	<u>Moderately</u>	<u>Quite a Bit</u>	<u>Extremely</u>
a. Do you currently feel safe in your workplace?	1	2	3	4	5
b. Do you currently feel safe in your home?.....	1	2	3	4	5
c. In general, how safe do you feel throughout your day in your usual activities and travel?.....	1	2	3	4	5

COUPLES' RELATIONSHIP
(If you are NOT married please go directly to PART IV)

C 7. Couples use many ways of trying to settle their differences. The following is a list of some things that you & your spouse/significant other (partner) might have done when you had a dispute. Thinking over your relationship, indicate whether you have experienced any of the events below by placing an "X" on the line if the event occurred in the **PAST MONTH**.

1. A Have you gotten information to back up your side of things
B Has your spouse (or partner) gotten information
2. A Have you tried to bring in someone to help settle things
B Has your spouse or partner.....
3. A Have you refused to give affection or sex to spouse
B Has your spouse or partner.....
4. A Have you insulted or sworn at your spouse.....
B Has your spouse or partner.....
5. A Have you sulked and/or refused to talk (during a conflict)
B Has your spouse or partner.....
6. A Have you stomped out of the room, house or yard.....
B Has your spouse or partner.....
7. A Have you cried (during a conflict)
B Has your spouse or partner.....
8. A Have you done or said something to spite spouse
B Has your spouse or partner.....
9. A Have you threatened to leave the marriage
B Has your spouse or partner.....
10. A Have you threatened to do things like take money, have an affair, etc. .
B Has your spouse or partner.....
11. A Have you tried to control your spouse physically (held down, etc.) .
B Has your spouse or partner.....
12. A Have you threatened to hit or throw something at your spouse
B Has your spouse or partner.....
13. A Have you thrown, smashed, hit, or kicked something.....
B Has your spouse or partner.....
14. A Have you driven recklessly to frighten your spouse
B Has your spouse or partner.....
15. A Have you thrown something at your spouse
B Has your spouse or partner.....
16. A Have you pushed, grabbed, or shoved your spouse.....
B Has your spouse or partner.....
17. A Have you slapped your spouse
B Has your spouse or partner.....
18. A Have you kicked, bit or hit your spouse with a fist.....
B Has your spouse or partner.....

19. A Have you choked or strangled your spouse..... _____
 B Has your spouse or partner..... _____
20. A Have you physically forced spouse to have sex..... _____
 B Has your spouse or partner..... _____
21. A Have you beat up your spouse _____
 B Has your spouse or partner..... _____
22. A Have you threatened your spouse with a knife or gun _____
 B Has your spouse or partner..... _____
23. A Have you used a knife or gun on your spouse..... _____
 B Has your spouse or partner..... _____
24. The numbers on the line below represent different degrees of happiness couples experience in their relationship. Circle the number directly on the scale below which best describes your **degree of happiness**, all things considered, in your relationship with your spouse:

Extremely UN-Happy	Fairly UN-Happy	A Little UN-Happy	Happy	Very Happy	Extremely Happy	Perfect
1	2	3	4	5	6	7

PART IV. PRESENT HEALTH & STRESS

- D 1. How many days during the past **MONTH** was your physical health not good? (*If the answer is none, put 00*).
 _____ number of days
- D 2. How many days during the past **MONTH** was your mental health not good? (*If the answer is none, put 00*)
 _____ number of days
- D 3. Over the past **MONTH** how often, on average, did you experience the following when at work?

	None of the Time	Some of the Time	Half of the Time	Most of the Time	All of the Time
a. Lose concentration.....	1	2	3	4	5
b. Repeat a job.....	1	2	3	4	5
c. Work more slowly than usual.....	1	2	3	4	5
d. Felt fatigued.....	1	2	3	4	5
e. Did nothing at work.....	1	2	3	4	5

- D 4. Have you obtained any **medical care** during the past **MONTH**?
- a. For physical problems..... 1. Yes 2. No
 - b. For emotional or family problems 1. Yes 2. No
 - c. Have you felt in need of medical care, but have not obtained any? ..1. Yes 2. No
- D 5. In the past MONTH did you change your **drinking habits**?
1. I do not drink alcohol
 2. **The amount I drank remained the same**
 3. I drank **more** than usual
 4. I drank **less** than usual
 5. I had stopped drinking but started again

- D 6. How many alcoholic drinks (*one 12 oz. beer, one glass of wine, or one cocktail*) do you usually drink at one time?
1. Never drink alcoholic beverages
 2. 1 drink
 3. 2 drinks
 4. 3-4 drinks
 5. 5-6 drinks
 6. 7-8 drinks
 7. More than 8 drinks

CAGE

- D 7. Have you ever felt you should cut down on your drinking? 1. Yes 2. No
- D 8. Have people annoyed you by criticizing your drinking? 1. Yes 2. No
- D 9. Have you felt bad or guilty about your drinking? 1. Yes 2. No
- D 10. Have you ever had a drink first thing in the morning to steady your Nerves or to get rid of a hangover (*eye-opener*)? 1. Yes 2. No

D 11. In the past **MONTH** did you change any **tobacco habits** (*cigarettes, snuff, cigars, chewing tobacco*)?

1. I do not use tobacco
2. My tobacco use **remained the same**
3. I **increased** my use of tobacco
4. I **decreased** my use of tobacco
5. I had stopped using tobacco but started using it again

STRESSFUL EXPERIENCES

D 12. Have **you** ever been in danger of being killed or injured (*if yes, please give age and describe*)?

- a. No never
- b. Yes, prior to deployment: age: ____; Please describe: _____
- c. Yes, during deployment: age: ____; Please describe: _____
- d. Yes, since last deployment: age: ____, Please describe: _____

D 13. Have you ever **witnessed someone** in danger of being killed or injured (*if yes, please give age and describe*)?

- a. No never
- b. Yes, prior to deployment: age: ____; Please describe: _____
- c. Yes, during deployment: age: ____; Please describe: _____
- d. Yes, since last deployment: age: ____, Please describe: _____

D 14. Thinking of the **most stressful life experiences above**, at the time it happened did you feel:

	<u>Not at All</u>	<u>A little Bit</u>	<u>Moderately</u>	<u>Quite a Bit</u>	<u>Extremely</u>
a. Frightened	0	1	2	3	4
b. Helpless	0	1	2	3	4
c. Anxious	0	1	2	3	4
d. Horrified.....	0	1	2	3	4
e. Hopeless.....	0	1	2	3	4
f. Angry	0	1	2	3	4

PCL-17

D 15. Below is a list of reactions that soldiers sometimes experience following stressful military or other life experiences. Please mark how much you have been bothered by each problem in the past MONTH.

	<u>Not at All</u>	<u>A Little Bit</u>	<u>Moderately</u>	<u>Quite a Bit</u>	<u>A lot</u>
1. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past.....	1	2	3	4	5
2. Repeated, disturbing dreams of a stressful experience from the past	1	2	3	4	5
3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)	1	2	3	4	5
4. Feeling very upset when something reminded you of a stressful experience from the past.....	1	2	3	4	5
5. Having physical reactions (like heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past	1	2	3	4	5
6. Avoiding thinking about or talking about a stressful experience from the past or avoiding having feelings related to it.....	1	2	3	4	5
7. Avoiding activities or situations because they reminded you of a stressful experience from the past	1	2	3	4	5
8. Trouble remembering important parts of a stressful experience from the past	1	2	3	4	5
9. Loss of interest in activities that you used to enjoy	1	2	3	4	5
10. Feeling distant or cut off from other people	1	2	3	4	5
11. Feeling emotionally numb or being unable to have loving feelings for those close to you.....	1	2	3	4	5
12. Feeling as if your future will somehow be cut short.....	1	2	3	4	5
13. Trouble falling or staying asleep.....	1	2	3	4	5
14. Feeling irritable or having angry outbursts	1	2	3	4	5
15. Having difficulty concentrating	1	2	3	4	5
16. Being super alert" or watchful or on-guard.....	1	2	3	4	5
17. Feeling jumpy or easily startled	1	2	3	4	5

D 16. What stressful experience were you thinking about when you answered the 17 items above?

D 17. How difficult have the above problems made it for you to do your work, take care of things at home or get along with other people?

1. Not at all difficult
2. Somewhat difficult
3. Very difficult
4. Extremely difficult

PHQ

D 18. Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

	<u>Not at All</u>	<u>Several Days</u>	<u>More than Half the Days</u>	<u>Nearly Every Day</u>
1. Little interest or pleasure in doing things	1	2	3	4
2. Feeling down, depressed, or hopeless	1	2	3	4
3. Trouble falling or staying asleep, or sleeping too much.....	1	2	3	4
4. Feeling tired or having little energy	1	2	3	4
5. Poor appetite or overeating.....	1	2	3	4
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down.....	1	2	3	4
7. Trouble concentrating on things, such as reading the newspaper or watching television	1	2	3	4
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been Moving around a lot more than usual.....	1	2	3	4
9. Thoughts that you would be better off dead or of hurting yourself in some way.....	1	2	3	4

D 19. Now thinking back over your life, has there ever been a time when you have been bothered by any of the above 9 problems for at least a 2 week period of time or more? (*if yes, please give age(s)*)

1. No
2. Yes: age(s) _____

BSI (SOM/HOS)

D 20. Below is a list of problems and complaints that people sometimes have. For each item below, indicate how much that problem has bothered or distressed you during the **PAST MONTH**.

	<u>Not At All</u>	<u>A Little Bit</u>	<u>Moderately</u>	<u>Quite A Bit</u>	<u>Extremely</u>
S 1. Faintness or dizziness.....	0	1	2	3	4
S 2. Pains in heart or chest.....	0	1	2	3	4
S 3. Nausea or upset stomach.....	0	1	2	3	4
S 4. Hot or cold spells.	0	1	2	3	4
S 5. Numbness or tingling in parts of your body.....	0	1	2	3	4
S 6. Feeling weak in parts of your body.....	0	1	2	3	4
H 7. Feeling easily annoyed or irritated.	0	1	2	3	4
H 8. Temper outbursts that you could not control.....	0	1	2	3	4
H 9. Having urges to beat, injure, or harm someone else..	0	1	2	3	4
H 10. Having urges to break or smash things.....	0	1	2	3	4
H 11. Getting into frequent arguments.	0	1	2	3	4

SEEKING CARE

D 21. Using the scale below, please rate each of the possible concerns that might affect your decision to receive mental health counseling or services during the past **MONTH**. (Circle only one number for each item.)

	<u>Strongly Disagree</u>	<u>Neutral</u>	<u>Strongly Agree</u>	
1. I don't trust mental health professionals	1	2	3	4
2. I don't know where to get help	1	2	3	4
3. I don't have adequate transportation	1	2	3	4
4. It is too difficult to schedule an appointment	1	2	3	4
5. There would be difficulty getting time off work or an appointment	1	2	3	4
6. Mental health care costs too much money	1	2	3	4
7. It would be too embarrassing	1	2	3	4
8. It would harm my career	1	2	3	4
9. Members of my unit would lose confidence in me	1	2	3	4
10. My leadership might treat me differently	1	2	3	4
11. My leaders would blame me for the problem	1	2	3	4
12. I would be seen as weak	1	2	3	4
13. Mental health care doesn't work	1	2	3	4

QUALITY OF LIFE (WHOQOL)

D 22. The following questions ask how you feel about your quality of life, health or other areas of your life. Please choose the answer that appears most appropriate. If you are unsure about which response to give to a question, the first response you think of is often the best one. Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life in the **last four weeks**.

	<u>Very Poor</u>	<u>Poor</u>	<u>Neither Poor nor Good</u>	<u>Good</u>	<u>Very Good</u>
a. How would you rate your quality of life?	1	2	3	4	5
b. How well are you able to get around?	1	2	3	4	5

	<u>Not at All</u>	<u>A Little</u>	<u>A Moderate Amount</u>	<u>Very Much</u>	<u>An Extreme Amount</u>
D 23.					
a. How much do you enjoy life?	1	2	3	4	5
b. To what extent do you feel your life to be meaningful?	1	2	3	4	5
c. To what extent do you feel that physical pain prevents you from doing what you need to do?	1	2	3	4	5
d. How much do you need any medical treatment to function in your daily life?	1	2	3	4	5

	<u>Very Dissatisfied</u>	<u>Dissatisfied</u>	<u>Neither Satisfied nor Dissatisfied</u>	<u>Satisfied</u>	<u>Very Satisfied</u>
D 24.					
a. How satisfied are you with your health?.....	1	2	3	4	5
b. How satisfied are you with yourself?	1	2	3	4	5
c. How satisfied are you with your personal relationships?....	1	2	3	4	5
d. How satisfied are you with your sex life?.....	1	2	3	4	5
e. How satisfied are you with the support you get from your friends?	1	2	3	4	5
f. How satisfied are you with the conditions of your living place?.....	1	2	3	4	5
g. How satisfied are you with your access to health services? 1		2	3	4	5
h. How satisfied are you with your transport?	1	2	3	4	5
i. How satisfied are you with your sleep?.....	1	2	3	4	5
j. How satisfied are you with your ability to perform your daily living activities?.....	1	2	3	4	5
k. How satisfied are you with your capacity for work?	1	2	3	4	5
D 25.	<u>Not at All</u>	<u>A Little</u>	<u>A Moderate Amount</u>	<u>Very Much</u>	<u>Extremely</u>
a. How well are you able to concentrate?.....	1	2	3	4	5
b. How safe do you feel in your daily life?.....	1	2	3	4	5
c. How healthy is your physical environment?.....	1	2	3	4	5
D 26.	<u>Not at All</u>	<u>A Little</u>	<u>Moderately</u>	<u>Mostly</u>	<u>Completely</u>
a. Do you have enough energy for everyday life?	1	2	3	4	5
b. Are you able to accept your bodily appearance?	1	2	3	4	5
c. Have you enough money to meet your needs?	1	2	3	4	5
d. How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
e. To what extent do you have the opportunity for leisure activities?	1	2	3	4	5
D 27.	<u>Never</u>	<u>Seldom</u>	<u>Quite Often</u>	<u>Very Often</u>	<u>Always</u>
How often do you have negative feelings such as blue mood, despair, anxiety, depression?.....	1	2	3	4	5

PART V. TEAM PROGRAM EVALUATION

The following questions are about your experience with our TEAM training program.

E 3. We are now interested in whether you have made use of the TEAM resources available to you and if so, **how helpful** have these resources been to you. *If you have NOT used the resource circle 6 (Not Applicable).*

	Not at All	A Little Bit	Moderately	Quite a Bit	A lot	NA
a. Handouts.....	1	2	3	4	5	6
b. Website.....	1	2	3	4	5	6
c. The 866 phone number	1	2	3	4	5	6
d. Email to study investigators	1	2	3	4	5	6

E 8. What would you like future sessions to address? (*Please list or describe below*):

↓ ↓ ↓

IF YOU HAVE ADDITIONAL COMMENTS OR IDEAS YOU WOULD LIKE TO SHARE WITH US, PLEASE USE THE SPACE BELOW & THE BACK OF THIS PAGE:

E3. Intervention Group Month 3 through Month 10 (Final Survey) Questionnaire

Questionnaire
Mortuary Affairs Soldiers
Troop Education for Army Morale (TEAM)
(Intervention Version)

Please Return to:

Carol S. Fullerton, Ph.D.
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Mortuary Affairs Soldiers: Early Intervention and Altering Barriers to Care

Uniformed Services University, Bethesda, MD

Mortuary Affairs Questionnaire

INSTRUCTIONS

During the past several years Army Mortuary Affairs soldiers have had many operational deployments. Preparing for deployments, the actual deployment, and return present many challenges for soldiers, families, units and communities. You have volunteered to participate in a program, the Post Deployment Program (PDP), to help with your return to post-deployment life and learn new skills that will be helpful at other times. Many of you who are participating in the PDP have taken a larger questionnaire in the past.

The purpose of this questionnaire you are taking today is to learn more about how you are feeling and what you have learned from our program. This questionnaire has many of the same questions you have seen before, but we need to understand what has changed for you since the last time you took it. Therefore, your responses are especially important to us to better prepare MA soldiers for return from future deployments.

There is no right or wrong answer to any of the questions. Just answer the questions the way you feel and write in whatever you want to where you are asked to provide a description or response. You do not have to answer any questions that make you feel uncomfortable, however, by not responding to all the questions limits what we can use from your questionnaire. You may discontinue participation in this study at any time.

ADDITIONAL INFORMATION

We need to use the information you have given us in previous questionnaires and for future questionnaires. In order to do that, we need to use the code that you used before. This is necessary order to be able to match this questionnaire with all others you have taken in the past and in the future. We still will not identify you as an individual or report on your individual responses. This code is a unique combination of letters and numbers that allows us to use your information without identifying you personally.

1. **Last letter** of your mother's maiden name: _____ (e.g., for "Smith" put "h")
2. **First letter** of the city you were born in: _____ (e.g., for "Baltimore" put "B")
3. **First letter** of the month you were born: _____ (e.g., for "July" put "J")
4. **Last digit** of the **day of the month** you were born: _____ (e.g., for "06 July" put "6"; or for "12 July" put "2")
5. **Last digit** of the **year** you were born: _____ (e.g., for "1976" put "6")

Print Name: _____

Address: _____

Phone: _____ Email: _____

Cell Phone: _____

PART I. BACKGROUND INFORMATION

Please answer the questions below by filling in the blanks or circling the number of the response that best applies.

A 1. Today's Date: / / D D / M M / Y Y

A 2. Your Age: ____ years

A 3. Your Sex: 1. Male 2. Female

A 4. Your Pay Grade (*e.g., E-5*): ____ - ____

A 5. Your Company: _____ MOS: _____

A 6. Highest level of education you have completed:

1. Less than 12th grade
2. High School or G.E.D.
3. Some College/Technical school
4. Bachelor's Degree
5. Graduate Degree (Masters or doctoral)

A 7. Racial/Ethnic Background:

1. American Indian or Alaskan Native
2. Asian or Pacific Islander
3. Black, not of Hispanic origin
4. Hispanic
5. White, not of Hispanic origin.

A 8. Are you currently married?

1. Yes If yes, number of years: _____
2. No

A 9. Do you currently live with your Spouse?

1. Yes
2. No
3. Not Applicable (*not married*)

A 10. Do you currently live with a Significant Other (*not including spouse, parents or children*)?

1. Yes, number of years: _____
2. No

PART II. MIDDLE EAST DEPLOYMENT

B 1. What was the **most stressful** part of your deployment to the Middle East? (*Please describe below*)

B 2. What has been the **most stressful** for you since your **return**. (*Please describe below*)

B 3. During your **deployment**, how often did you think you were in danger of being injured or killed?

1. Never
2. Once or twice
3. A number of times
4. Many times.

B 4. Did you work with any casualties or dead on your most recent deployment to the Middle East?

1. Yes
2. No
3. Not Applicable, I have not deployed to the Middle East

If Yes, *please describe your experience(s) working with casualties:*

PART III. PRESENT EXPERIENCE

C 1. Using the scale below, for each item circle the number that best describes **you at the present time**.

	Very Low	Medium	Very High
a. Your personal morale.....	1	2	3
b. Your level of motivation.....	1	2	3
c. Your level of energy.....	1	2	3
d. Your level of drive.....	1	2	4

C 2. Using the scale below, circle one number per item that best describes **your Unit at the present time**.

	Strongly Disagree	Neutral	Strongly Agree
a. The members of my unit are cooperative with each other.....	1	2	3
b. The members of my unit know they can depend on each other	1	2	3
c. The members of my unit stand up for each other	1	2	3
d. The leaders of this company would lead well in combat.	1	2	4
e. I am impressed by the quality of leadership in this company.....	1	2	4
f. My chain of command works well.....	1	2	4

C 3. What kind of **problems** have you encountered during the past **MONTH**?

- a. Unit problems..... 1. Yes 2. No 3. NA
- b. Marital problems 1. Yes 2. No 3. NA
- c. Personal problems 1. Yes 2. No 3. NA
- d. Problems with child(ren)..... 1. Yes 2. No 3. NA
- e. Religious/spiritual problems..... 1. Yes 2. No 3. NA
- f. Problems with parents..... 1. Yes 2. No 3. NA
- g. In-law problems 1. Yes 2. No 3. NA
- h. Financial problems 1. Yes 2. No 3. NA
- i. Medical problems..... 1. Yes 2. No 3. NA
- j. Other _____ 1. Yes 2. No 3. NA

If yes, **Please Describe the Problems:**

C 4. Current legal and medical issues. Please circle your response to each of the following items.

- a. Are you currently undergoing a medical board? 1. Yes 2. No 3. Don't know
- b. Are you currently being processed for an administrative discharge? 1. Yes 2. No 3. Don't know
- c. Are you currently being processed for any other UCMJ action 1. Yes 2. No 3. Don't know
(such as a court martial)?

If yes, **Please Describe the Problems:**

C 5. Rate the current **degree of support or lack of support** – emotional and practical – you feel from each of the following individuals:

	<u>None</u>	<u>Moderate</u>	<u>A Great Deal</u>	<u>Not Applicable</u>
a. Family	0	1	2	3
b. Friends	0	1	2	3
c. Co-Workers.....	0	1	2	4
d. Supervisors.....	0	1	2	5

C 6. Below are questions about how safe you have been feeling:

	<u>Not at All</u>	<u>A Little Bit</u>	<u>Moderately</u>	<u>Quite a Bit</u>	<u>Extremely</u>
a. Do you currently feel safe in your workplace?	1	2	3	4	5
b. Do you currently feel safe in your home?.....	1	2	3	4	5
c. In general, how safe do you feel throughout your day in your usual activities and travel?.....	1	2	3	4	5

COUPLES' RELATIONSHIP

(If you are NOT married please go directly to PART IV)

C 7. Couples use many ways of trying to settle their differences. The following is a list of some things that you & your spouse/significant other (partner) might have done when you had a dispute. Thinking over your relationship, indicate whether you have experienced any of the events below by placing an "X" on the line if the event occurred in the **PAST MONTH**.

1. A Have you gotten information to back up your side of things
B Has your spouse (or partner) gotten information
2. A Have you tried to bring in someone to help settle things
B Has your spouse or partner.....
3. A Have you refused to give affection or sex to spouse
B Has your spouse or partner.....
4. A Have you insulted or sworn at your spouse.....
B Has your spouse or partner.....
5. A Have you sulked and/or refused to talk (during a conflict)
B Has your spouse or partner.....
6. A Have you stomped out of the room, house or yard.....
B Has your spouse or partner.....
7. A Have you cried (during a conflict)
B Has your spouse or partner.....
8. A Have you done or said something to spite spouse
B Has your spouse or partner.....
9. A Have you threatened to leave the marriage
B Has your spouse or partner.....
10. A Have you threatened to do things like take money, have an affair, etc. .
B Has your spouse or partner.....
11. A Have you tried to control your spouse physically (held down, etc.) .
B Has your spouse or partner.....
12. A Have you threatened to hit or throw something at your spouse
B Has your spouse or partner.....
13. A Have you thrown, smashed, hit, or kicked something.....
B Has your spouse or partner.....
14. A Have you driven recklessly to frighten your spouse
B Has your spouse or partner.....
15. A Have you thrown something at your spouse
B Has your spouse or partner.....
16. A Have you pushed, grabbed, or shoved your spouse.....
B Has your spouse or partner.....
17. A Have you slapped your spouse
B Has your spouse or partner.....
18. A Have you kicked, bit or hit your spouse with a fist.....
B Has your spouse or partner.....

19. A Have you choked or strangled your spouse..... _____
 B Has your spouse or partner..... _____
20. A Have you physically forced spouse to have sex..... _____
 B Has your spouse or partner..... _____
21. A Have you beat up your spouse _____
 B Has your spouse or partner..... _____
22. A Have you threatened your spouse with a knife or gun _____
 B Has your spouse or partner..... _____
23. A Have you used a knife or gun on your spouse..... _____
 B Has your spouse or partner..... _____
24. The numbers on the line below represent different degrees of happiness couples experience in their relationship. Circle the number directly on the scale below which best describes your **degree of happiness**, all things considered, in your relationship with your spouse:



PART IV. PRESENT HEALTH & STRESS

- D 1. How many days during the past **MONTH** was your physical health not good? (*If the answer is none, put 00*).
 _____ number of days
- D 2. How many days during the past **MONTH** was your mental health not good? (*If the answer is none, put 00*)
 _____ number of days
- D 3. Over the past **MONTH** how often, on average, did you experience the following when at work?

	None of the Time	Some of the Time	Half of the Time	Most of the Time	All of the Time
a. Lose concentration.....	1	2	3	4	5
b. Repeat a job.....	1	2	3	4	5
c. Work more slowly than usual.....	1	2	3	4	5
d. Felt fatigued.....	1	2	3	4	5
e. Did nothing at work.....	1	2	3	4	5

- D 4. Have you obtained any **medical care** during the past **MONTH**?
- For physical problems..... 1. Yes 2. No
 - For emotional or family problems 1. Yes 2. No
 - Have you felt in need of medical care, but have not obtained any? 1. Yes 2. No
- D 5. In the past MONTH did you change your **drinking habits**?
- I do not drink alcohol
 - The amount I drank remained the same**
 - I drank **more** than usual
 - I drank **less** than usual
 - I had stopped drinking but started again

- D 6. How many alcoholic drinks (*one 12 oz. beer, one glass of wine, or one cocktail*) do you usually drink at one time?
1. Never drink alcoholic beverages
 2. 1 drink
 3. 2 drinks
 4. 3-4 drinks
 5. 5-6 drinks
 6. 7-8 drinks
 7. More than 8 drinks

CAGE

- D 7. Have you ever felt you should cut down on your drinking? 1. Yes 2. No
- D 8. Have people annoyed you by criticizing your drinking? 1. Yes 2. No
- D 9. Have you felt bad or guilty about your drinking? 1. Yes 2. No
- D 10. Have you ever had a drink first thing in the morning to steady your Nerves or to get rid of a hangover (*eye-opener*)? 1. Yes 2. No

D 11. In the past **MONTH** did you change any **tobacco habits** (*cigarettes, snuff, cigars, chewing tobacco*)?

1. I do not use tobacco
2. My tobacco use **remained the same**
3. I **increased** my use of tobacco
4. I **decreased** my use of tobacco
5. I had stopped using tobacco but started using it again

STRESSFUL EXPERIENCES

D 12. Have **you** ever been in danger of being killed or injured (*if yes, please give age and describe*)?

- a. No never
- b. Yes, prior to deployment: age: ____; Please describe: _____
- c. Yes, during deployment: age: ____; Please describe: _____
- d. Yes, since last deployment: age: ____, Please describe: _____

D 13. Have you ever **witnessed someone** in danger of being killed or injured (*if yes, please give age and describe*)?

- a. No never
- b. Yes, prior to deployment: age: ____; Please describe: _____
- c. Yes, during deployment: age: ____; Please describe: _____
- d. Yes, since last deployment: age: ____, Please describe: _____

D 14. Thinking of the **most stressful life experiences above**, at the time it happened did you feel:

	<u>Not at All</u>	<u>A little Bit</u>	<u>Moderately</u>	<u>Quite a Bit</u>	<u>Extremely</u>
a. Frightened	0	1	2	3	4
b. Helpless	0	1	2	3	4
c. Anxious	0	1	2	3	4
d. Horrified.....	0	1	2	3	4
e. Hopeless.....	0	1	2	3	4
f. Angry	0	1	2	3	4

PCL-17

D 15. Below is a list of reactions that soldiers sometimes experience following stressful military or other life experiences. Please mark how much you have been bothered by each problem in the past MONTH.

	<u>Not at All</u>	<u>A Little Bit</u>	<u>Moderately</u>	<u>Quite a Bit</u>	<u>A lot</u>
1. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past.....	1	2	3	4	5
2. Repeated, disturbing dreams of a stressful experience from the past	1	2	3	4	5
3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)	1	2	3	4	5
4. Feeling very upset when something reminded you of a stressful experience from the past.....	1	2	3	4	5
5. Having physical reactions (like heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past	1	2	3	4	5
6. Avoiding thinking about or talking about a stressful experience from the past or avoiding having feelings related to it.....	1	2	3	4	5
7. Avoiding activities or situations because they reminded you of a stressful experience from the past	1	2	3	4	5
8. Trouble remembering important parts of a stressful experience from the past	1	2	3	4	5
9. Loss of interest in activities that you used to enjoy	1	2	3	4	5
10. Feeling distant or cut off from other people	1	2	3	4	5
11. Feeling emotionally numb or being unable to have loving feelings for those close to you.....	1	2	3	4	5
12. Feeling as if your future will somehow be cut short.....	1	2	3	4	5
13. Trouble falling or staying asleep	1	2	3	4	5
14. Feeling irritable or having angry outbursts.....	1	2	3	4	5
15. Having difficulty concentrating.....	1	2	3	4	5
16. Being super alert" or watchful or on-guard.....	1	2	3	4	5
17. Feeling jumpy or easily startled.....	1	2	3	4	5

D 16. What stressful experience were you thinking about when you answered the 17 items above?

D 17. How difficult have the above problems made it for you to do your work, take care of things at home or get along with other people?

1. Not at all difficult
2. Somewhat difficult
3. Very difficult
4. Extremely difficult

PHQ

D 18. Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

	<u>Not at All</u>	<u>Several Days</u>	<u>More than Half the Days</u>	<u>Nearly Every Day</u>
1. Little interest or pleasure in doing things	1	2	3	4
2. Feeling down, depressed, or hopeless	1	2	3	4
3. Trouble falling or staying asleep, or sleeping too much.....	1	2	3	4
4. Feeling tired or having little energy	1	2	3	4
5. Poor appetite or overeating.....	1	2	3	4
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	1	2	3	4
7. Trouble concentrating on things, such as reading the newspaper or watching television	1	2	3	4
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been Moving around a lot more than usual.....	1	2	3	4
9. Thoughts that you would be better off dead or of hurting yourself in some way.....	1	2	3	4

D 19. Now thinking back over your life, has there ever been a time when you have been bothered by any of the above 9 problems for at least a 2 week period of time or more? (*if yes, please give age(s)*)

1. No
2. Yes: age(s) _____

BSI (SOM/HOS)

D 20. Below is a list of problems and complaints that people sometimes have. For each item below, indicate how much that problem has bothered or distressed you during the **PAST MONTH**.

	<u>Not At All</u>	<u>A Little Bit</u>	<u>Moderately</u>	<u>Quite A Bit</u>	<u>Extremely</u>
S 1. Faintness or dizziness.....	0	1	2	3	4
S 2. Pains in heart or chest.....	0	1	2	3	4
S 3. Nausea or upset stomach.....	0	1	2	3	4
S 4. Hot or cold spells.....	0	1	2	3	4
S 5. Numbness or tingling in parts of your body.....	0	1	2	3	4
S 6. Feeling weak in parts of your body.....	0	1	2	3	4
H 7. Feeling easily annoyed or irritated.....	0	1	2	3	4
H 8. Temper outbursts that you could not control.....	0	1	2	3	4
H 9. Having urges to beat, injure, or harm someone else..	0	1	2	3	4
H 10. Having urges to break or smash things.....	0	1	2	3	4
H 11. Getting into frequent arguments.....	0	1	2	3	4

SEEKING CARE

D 21. Using the scale below, please rate each of the possible concerns that might affect your decision to receive mental health counseling or services during the past **MONTH**. (Circle only one number for each item.)

	<u>Strongly Disagree</u>	<u>Neutral</u>	<u>Strongly Agree</u>	
1. I don't trust mental health professionals	1	2	3	4
2. I don't know where to get help	1	2	3	4
3. I don't have adequate transportation	1	2	3	4
4. It is too difficult to schedule an appointment	1	2	3	4
5. There would be difficulty getting time off work or an appointment	1	2	3	4
6. Mental health care costs too much money	1	2	3	4
7. It would be too embarrassing	1	2	3	4
8. It would harm my career	1	2	3	4
9. Members of my unit would lose confidence in me	1	2	3	4
10. My leadership might treat me differently	1	2	3	4
11. My leaders would blame me for the problem	1	2	3	4
12. I would be seen as weak	1	2	3	4
13. Mental health care doesn't work	1	2	3	4

QUALITY OF LIFE (WHOQOL)

D 22. The following questions ask how you feel about your quality of life, health or other areas of your life. Please choose the answer that appears most appropriate. If you are unsure about which response to give to a question, the first response you think of is often the best one. Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life in the **last four weeks**.

	<u>Very Poor</u>	<u>Poor</u>	<u>Neither Poor nor Good</u>	<u>Good</u>	<u>Very Good</u>
a. How would you rate your quality of life?	1	2	3	4	5
b. How well are you able to get around?	1	2	3	4	5

D 23.		<u>Not at All</u>	<u>A Little</u>	<u>A Moderate Amount</u>	<u>Very Much</u>	<u>An Extreme Amount</u>
		<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
	a. How much do you enjoy life?	1	2	3	4	5
	b. To what extent do you feel your life to be meaningful?	1	2	3	4	5
	c. To what extent do you feel that physical pain prevents you from doing what you need to do?	1	2	3	4	5
	d. How much do you need any medical treatment to function in your daily life?	1	2	3	4	5

	<u>Very Dissatisfied</u>	<u>Dissatisfied</u>	<u>Neither Satisfied nor Dissatisfied</u>	<u>Satisfied</u>	<u>Very Satisfied</u>
D 24.					
a. How satisfied are you with your health?.....	1	2	3	4	5
b. How satisfied are you with yourself?	1	2	3	4	5
c. How satisfied are you with your personal relationships?....	1	2	3	4	5
d. How satisfied are you with your sex life?.....	1	2	3	4	5
e. How satisfied are you with the support you get from your friends?	1	2	3	4	5
f. How satisfied are you with the conditions of your living place?.....	1	2	3	4	5
g. How satisfied are you with your access to health services? 1		2	3	4	5
h. How satisfied are you with your transport?	1	2	3	4	5
i. How satisfied are you with your sleep?.....	1	2	3	4	5
j. How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
k. How satisfied are you with your capacity for work?	1	2	3	4	5
D 25.	<u>Not at All</u>	<u>A Little</u>	<u>A Moderate Amount</u>	<u>Very Much</u>	<u>Extremely</u>
a. How well are you able to concentrate?.....	1	2	3	4	5
b. How safe do you feel in your daily life?.....	1	2	3	4	5
c. How healthy is your physical environment?.....	1	2	3	4	5
D 26.	<u>Not at All</u>	<u>A Little</u>	<u>Moderately</u>	<u>Mostly</u>	<u>Completely</u>
a. Do you have enough energy for everyday life?	1	2	3	4	5
b. Are you able to accept your bodily appearance?	1	2	3	4	5
c. Have you enough money to meet your needs?	1	2	3	4	5
d. How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
e. To what extent do you have the opportunity for leisure activities?	1	2	3	4	5
D 27.	<u>Never</u>	<u>Seldom</u>	<u>Quite Often</u>	<u>Very Often</u>	<u>Always</u>
How often do you have negative feelings such as blue mood, despair, anxiety, depression?.....	1	2	3	4	5

PART V. TEAM PROGRAM EVALUATION

The following questions are about your experience with our TEAM training program.

E 1. How helpful has the training been in:

	<u>Not at All</u>	<u>A Little Bit</u>	<u>Moderately</u>	<u>Quite a Bit</u>	<u>A lot</u>
a. Recognizing problems you have been having in re-adjusting to garrison and/or family life.....	1	2	3	4	5
b. Talking with people about your concerns and problems.....	1	2	3	4	5
c. Taking care of yourself and managing stress	1	2	3	4	5
d. Making it easier for you to ask for, or seek care.....	1	2	3	4	5

E 2. How much has the TEAM training helped you in the following areas?

	<u>Not at All</u>	<u>A Little Bit</u>	<u>Moderately</u>	<u>Quite a Bit</u>	<u>A lot</u>
a. Feeling safe	1	2	3	4	5
b. Relaxation techniques	1	2	3	4	5
c. Communicating with others	1	2	3	4	5
d. Connecting with others (<i>turning to others for support if needed</i>)	1	2	3	4	5
e. Problem solving	1	2	3	4	5
f. Providing support to a buddy	1	2	3	4	5
g. Having a positive outlook on things.....	1	2	3	4	5

E 3. We are now interested in whether you have made use of the TEAM resources available to you and if so, **how helpful** have these resources been to you. *If you have NOT used the resource circle 6 (Not Applicable).*

	<u>Not at All</u>	<u>A Little Bit</u>	<u>Moderately</u>	<u>Quite a Bit</u>	<u>A lot</u>	<u>NA</u>
a. Handouts.....	1	2	3	4	5	6
b. Website.....	1	2	3	4	5	6
c. The 866 phone number	1	2	3	4	5	6
d. Email to study investigators	1	2	3	4	5	6

E 4. Overall, did you find the TEAM training helpful to you?

1. Yes
2. No

E 5. What have you found **most helpful** about the TEAM program? (*Please describe below*):

E 6. What have you found **least helpful** about the TEAM program? (*Please describe below*):

E 7. What else could we have included for you in our program that could have been helpful? (*Please describe below*):

E 8. What would you like future sessions to address? (*Please list or describe below*):

IF YOU HAVE ADDITIONAL COMMENTS or IDEAS YOU WOULD LIKE to SHARE WITH US, PLEASE USE the
SPACE BELOW & THE BACK OF THIS PAGE:

E4. Comparison Group Month 2 through Month 10 (Final Survey) Questionnaire

Questionnaire
Mortuary Affairs Soldiers
Troop Education for Army Morale (TEAM)
(Usual Care Version)

Please Return to:

Carol S. Fullerton, Ph.D.
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Uniformed Services University of the Health Sciences
4301 Jones Bridge Road
Bethesda, Maryland 20814-4799

Mortuary Affairs Soldiers: Early Intervention and Altering Barriers to Care

Uniformed Services University, Bethesda, MD

Mortuary Affairs Questionnaire

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1. **Last letter** of your mother's maiden name: _____ (e.g., for "Smith" put "h")
2. **First letter** of the city you were born in: _____ (e.g., for "Baltimore" put "B")
3. **First letter** of the month you were born: _____ (e.g., for "July" put "J")
4. **Last digit** of the **day of the month** you were born: _____ (e.g., for "06 July" put "6"; or for "12 July" put "2")
5. **Last digit** of the **year** you were born: _____ (e.g., for "1976" put "6")

Print Name: _____

Address: _____

Phone: _____ Email: _____

Cell Phone: _____

PART I. BACKGROUND INFORMATION

Please answer the questions below by filling in the blanks or circling the number of the response that best applies.

A 1. Today's Date: / / D D / M M / Y Y

A 2. Your Age: ____ years

A 3. Your Sex: 1. Male 2. Female

A 4. Your Pay Grade (*e.g., E-5*): ____ - ____

A 5. Your Company: _____ MOS: _____

A 6. Highest level of education you have completed:

1. Less than 12th grade
2. High School or G.E.D.
3. Some College/Technical school
4. Bachelor's Degree
5. Graduate Degree (Masters or doctoral)

A 7. Racial/Ethnic Background:

1. American Indian or Alaskan Native
2. Asian or Pacific Islander
3. Black, not of Hispanic origin
4. Hispanic
5. White, not of Hispanic origin.

A 8. Are you currently married?

1. Yes If yes, number of years: _____
2. No

A 9. Do you currently live with your Spouse?

1. Yes
2. No
3. Not Applicable (*not married*)

A 10. Do you currently live with a Significant Other (*not including spouse, parents or children*)?

1. Yes, number of years: _____
2. No

PART II. MIDDLE EAST DEPLOYMENT

B 1. What was the **most stressful** part of your deployment to the Middle East? (*Please describe below*)

B 2. What has been the **most stressful** for you since your **return**. (*Please describe below*)

B 3. During your **deployment**, how often did you think you were in danger of being injured or killed?

1. Never
2. Once or twice
3. A number of times
4. Many times.

B 4. Did you work with any casualties or dead on your most recent deployment to the Middle East?

1. Yes
2. No
3. Not Applicable, I have not deployed to the Middle East

If Yes, *please describe your experience(s) working with casualties:*

PART III. PRESENT EXPERIENCE

C 1. Using the scale below, for each item circle the number that best describes **you at the present time**.

	Very Low	Medium	Very High
a. Your personal morale.....	1	2	3
b. Your level of motivation.....	1	2	4
c. Your level of energy.....	1	2	4
d. Your level of drive.....	1	2	5

C 2. Using the scale below, circle one number per item that best describes **your Unit at the present time**.

	Strongly Disagree	Neutral	Strongly Agree
a. The members of my unit are cooperative with each other.....	1	2	3
b. The members of my unit know they can depend on each other	1	2	4
c. The members of my unit stand up for each other	1	2	5
d. The leaders of this company would lead well in combat.....	1	2	4
e. I am impressed by the quality of leadership in this company.....	1	2	4
f. My chain of command works well.....	1	2	5

C 3. What kind of **problems** have you encountered during the past **MONTH**?

- a. Unit problems 1. Yes 2. No 3. NA
- b. Marital problems 1. Yes 2. No 3. NA
- c. Personal problems 1. Yes 2. No 3. NA
- d. Problems with child(ren) 1. Yes 2. No 3. NA
- e. Religious/spiritual problems 1. Yes 2. No 3. NA
- f. Problems with parents 1. Yes 2. No 3. NA
- g. In-law problems 1. Yes 2. No 3. NA
- h. Financial problems 1. Yes 2. No 3. NA
- i. Medical problems 1. Yes 2. No 3. NA
- j. Other _____ 1. Yes 2. No 3. NA

If yes, **Please Describe the Problems:**

C 4. Current legal and medical issues. Please circle your response to each of the following items.

- a. Are you currently undergoing a medical board? 1. Yes 2. No 3. Don't know
- b. Are you currently being processed for an administrative discharge? 1. Yes 2. No 3. Don't know
- c. Are you currently being processed for any other UCMJ action 1. Yes 2. No 3. Don't know
(such as a court martial)?

If yes, **Please Describe the Problems:**

C 5. Rate the current **degree of support or lack of support** – emotional and practical – you feel from each of the following individuals:

	<u>None</u>	<u>Moderate</u>	<u>A Great Deal</u>	<u>Not Applicable</u>
a. Family	0	1	2	3
b. Friends	0	1	2	3
c. Co-Workers	0	1	2	3
d. Supervisors.....	0	1	2	4

C 6. Below are questions about how safe you have been feeling:

	<u>Not at All</u>	<u>A Little Bit</u>	<u>Moderately</u>	<u>Quite a Bit</u>	<u>Extremely</u>
a. Do you currently feel safe in your workplace?	1	2	3	4	5
b. Do you currently feel safe in your home?.....	1	2	3	4	5
c. In general, how safe do you feel throughout your day in your usual activities and travel?	1	2	3	4	5

COUPLES' RELATIONSHIP
(If you are NOT married please go directly to PART IV)

C 7. Couples use many ways of trying to settle their differences. The following is a list of some things that you & your spouse/significant other (partner) might have done when you had a dispute. Thinking over your relationship, indicate whether you have experienced any of the events below by placing an "X" on the line if the event occurred in the **PAST MONTH**.

1. A Have you gotten information to back up your side of things
B Has your spouse (or partner) gotten information
2. A Have you tried to bring in someone to help settle things
B Has your spouse or partner.....
3. A Have you refused to give affection or sex to spouse
B Has your spouse or partner.....
4. A Have you insulted or sworn at your spouse.....
B Has your spouse or partner.....
5. A Have you sulked and/or refused to talk (during a conflict)
B Has your spouse or partner.....
6. A Have you stomped out of the room, house or yard.....
B Has your spouse or partner.....
7. A Have you cried (during a conflict)
B Has your spouse or partner.....
8. A Have you done or said something to spite spouse
B Has your spouse or partner.....
9. A Have you threatened to leave the marriage
B Has your spouse or partner.....
10. A Have you threatened to do things like take money, have an affair, etc. .
B Has your spouse or partner.....
11. A Have you tried to control your spouse physically (held down, etc.) .
B Has your spouse or partner.....
12. A Have you threatened to hit or throw something at your spouse
B Has your spouse or partner.....
13. A Have you thrown, smashed, hit, or kicked something.....
B Has your spouse or partner.....
14. A Have you driven recklessly to frighten your spouse
B Has your spouse or partner.....
15. A Have you thrown something at your spouse
B Has your spouse or partner.....
16. A Have you pushed, grabbed, or shoved your spouse.....
B Has your spouse or partner.....
17. A Have you slapped your spouse
B Has your spouse or partner.....
18. A Have you kicked, bit or hit your spouse with a fist.....
B Has your spouse or partner.....

19. A Have you choked or strangled your spouse..... ____
 B Has your spouse or partner..... ____
20. A Have you physically forced spouse to have sex..... ____
 B Has your spouse or partner..... ____
21. A Have you beat up your spouse ____
 B Has your spouse or partner..... ____
22. A Have you threatened your spouse with a knife or gun ____
 B Has your spouse or partner..... ____
23. A Have you used a knife or gun on your spouse..... ____
 B Has your spouse or partner..... ____
24. The numbers on the line below represent different degrees of happiness couples experience in their relationship. Circle the number directly on the scale below which best describes your **degree of happiness**, all things considered, in your relationship with your spouse:

Extremely UN-Happy	Fairly UN-Happy	A Little UN-Happy	Happy	Very Happy	Extremely Happy	Perfect
1	2	3	4	5	6	7

PART IV. PRESENT HEALTH & STRESS

- D 1. How many days during the past **MONTH** was your physical health not good? (*If the answer is none, put 00*).
 _____ number of days
- D 2. How many days during the past **MONTH** was your mental health not good? (*If the answer is none, put 00*)
 _____ number of days
- D 3. Over the past **MONTH** how often, on average, did you experience the following when at work?

	None of the Time	Some of the Time	Half of the Time	Most of the Time	All of the Time
a. Lose concentration.....	1	2	3	4	5
b. Repeat a job.....	1	2	3	4	5
c. Work more slowly than usual.....	1	2	3	4	5
d. Felt fatigued.....	1	2	3	4	5
e. Did nothing at work.....	1	2	3	4	5

- D 4. Have you obtained any **medical care** during the past **MONTH**?
- For physical problems 1. Yes 2. No
 - For emotional or family problems..... 1. Yes 2. No
 - Have you felt in need of medical care, but have not obtained any?.. 1. Yes 2. No
- D 5. In the past **MONTH** did you change your **drinking habits**?
- I do not drink alcohol
 - The amount I drank remained the same**
 - I drank **more** than usual
 - I drank **less** than usual
 - I had stopped drinking but started again

- D 6. How many alcoholic drinks (*one 12 oz. beer, one glass of wine, or one cocktail*) do you usually drink at one time?
1. Never drink alcoholic beverages
 2. 1 drink
 3. 2 drinks
 4. 3-4 drinks
 5. 5-6 drinks
 6. 7-8 drinks
 7. More than 8 drinks

CAGE

- D 7. Have you ever felt you should cut down on your drinking? 1. Yes 2. No
- D 8. Have people annoyed you by criticizing your drinking? 1. Yes 2. No
- D 9. Have you felt bad or guilty about your drinking? 1. Yes 2. No
- D 10. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (*eye-opener*)? 1. Yes 2. No

D 11. In the past **MONTH** did you change any **tobacco habits** (*cigarettes, snuff, cigars, chewing tobacco*)?

1. I do not use tobacco
2. My tobacco use **remained the same**
3. I **increased** my use of tobacco
4. I **decreased** my use of tobacco
5. I had stopped using tobacco but started using it again

STRESSFUL EXPERIENCES

D 12. Have **you** ever been in danger of being killed or injured (*if yes, please give age and describe*)?

- a. No never
- b. Yes, prior to deployment: age: ____; Please describe: _____
- c. Yes, during deployment: age: ____; Please describe: _____
- d. Yes, since last deployment: age: ____, Please describe: _____

D 13. Have you ever **witnessed someone** in danger of being killed or injured (*if yes, please give age and describe*)?

- a. No never
- b. Yes, prior to deployment: age: ____; Please describe: _____
- c. Yes, during deployment: age: ____; Please describe: _____
- d. Yes, since last deployment: age: ____, Please describe: _____

D 14. Thinking of the **most stressful life experiences above**, at the time it happened did you feel:

	<u>Not at All</u>	<u>A little Bit</u>	<u>Moderately</u>	<u>Quite a Bit</u>	<u>Extremely</u>
a. Frightened	0	1	2	3	4
b. Helpless	0	1	2	3	4
c. Anxious	0	1	2	3	4
d. Horrified.....	0	1	2	3	4
e. Hopeless.....	0	1	2	3	4
f. Angry	0	1	2	3	4

PCL-17

D 15. Below is a list of reactions that soldiers sometimes experience following stressful military or other life experiences. Please mark how much you have been bothered by each problem in **the past MONTH**.

	<u>Not at All</u>	<u>A Little Bit</u>	<u>Moderately</u>	<u>Quite a Bit</u>	<u>A lot</u>
1. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past.....	1	2	3	4	5
2. Repeated, disturbing dreams of a stressful experience from the past	1	2	3	4	5
3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)	1	2	3	4	5
4. Feeling very upset when something reminded you of a stressful experience from the past.....	1	2	3	4	5
5. Having physical reactions (like heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past	1	2	3	4	5
6. Avoiding thinking about or talking about a stressful experience from the past or avoiding having feelings related to it.....	1	2	3	4	5
7. Avoiding activities or situations because they reminded you of a stressful experience from the past	1	2	3	4	5
8. Trouble remembering important parts of a stressful experience from the past	1	2	3	4	5
9. Loss of interest in activities that you used to enjoy	1	2	3	4	5
10. Feeling distant or cut off from other people	1	2	3	4	5
11. Feeling emotionally numb or being unable to have loving feelings for those close to you.....	1	2	3	4	5
12. Feeling as if your future will somehow be cut short.....	1	2	3	4	5
13. Trouble falling or staying asleep	1	2	3	4	5
14. Feeling irritable or having angry outbursts.....	1	2	3	4	5
15. Having difficulty concentrating.....	1	2	3	4	5
16. Being super alert" or watchful or on-guard.....	1	2	3	4	5
17. Feeling jumpy or easily startled.....	1	2	3	4	5

D 16. What stressful experience were you thinking about when you answered the 17 items above?

D 17. How difficult have the above problems made it for you to do your work, take care of things at home or get along with other people?

1. Not at all difficult
2. Somewhat difficult
3. Very difficult
4. Extremely difficult

PHQ

D 18. Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

	<u>Not at All</u>	<u>Several Days</u>	<u>More than Half the Days</u>	<u>Nearly Every Day</u>
1. Little interest or pleasure in doing things.....	1	2	3	4
2. Feeling down, depressed, or hopeless	1	2	3	4
3. Trouble falling or staying asleep, or sleeping too much.....	1	2	3	4
4. Feeling tired or having little energy	1	2	3	4
5. Poor appetite or overeating.....	1	2	3	4
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	1	2	3	4
7. Trouble concentrating on things, such as reading the newspaper or watching television.....	1	2	3	4
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been Moving around a lot more than usual.....	1	2	3	4
9. Thoughts that you would be better off dead or of hurting yourself in some way.....	1	2	3	4

D 19. Now thinking back over your life, has there ever been a time when you have been bothered by any of the above 9 problems for at least a 2 week period of time or more? (*if yes, please give age(s)*)

1. No
2. Yes: age(s) _____

BSI (SOM/HOS)

D 20. Below is a list of problems and complaints that people sometimes have. For each item below, indicate how much that problem has bothered or distressed you during the **PAST MONTH**.

	<u>Not At All</u>	<u>A Little Bit</u>	<u>Moderately</u>	<u>Quite A Bit</u>	<u>Extremely</u>
S 1. Faintness or dizziness.....	0	1	2	3	4
S 2. Pains in heart or chest.....	0	1	2	3	4
S 3. Nausea or upset stomach.....	0	1	2	3	4
S 4. Hot or cold spells.....	0	1	2	3	4
S 5. Numbness or tingling in parts of your body.....	0	1	2	3	4
S 6. Feeling weak in parts of your body.....	0	1	2	3	4
H 7. Feeling easily annoyed or irritated.....	0	1	2	3	4
H 8. Temper outbursts that you could not control.....	0	1	2	3	4
H 9. Having urges to beat, injure, or harm someone else..	0	1	2	3	4
H 10. Having urges to break or smash things.....	0	1	2	3	4
H 11. Getting into frequent arguments.....	0	1	2	3	4

SEEKING CARE

D 21. Using the scale below, please rate each of the possible concerns that might affect your decision to receive mental health counseling or services during the past **MONTH**. (Circle only one number for each item.)

	<u>Strongly Disagree</u>	<u>Neutral</u>	<u>Strongly Agree</u>	
1. I don't trust mental health professionals	1	2	3	4
2. I don't know where to get help	1	2	3	4
3. I don't have adequate transportation	1	2	3	4
4. It is too difficult to schedule an appointment	1	2	3	4
5. There would be difficulty getting time off work or an appointment	1	2	3	4
6. Mental health care costs too much money	1	2	3	4
7. It would be too embarrassing	1	2	3	4
8. It would harm my career	1	2	3	4
9. Members of my unit would lose confidence in me	1	2	3	4
10. My leadership might treat me differently	1	2	3	4
11. My leaders would blame me for the problem	1	2	3	4
12. I would be seen as weak	1	2	3	4
13. Mental health care doesn't work	1	2	3	4

QUALITY OF LIFE (WHOQOL)

D 22. The following questions ask how you feel about your quality of life, health or other areas of your life. Please choose the answer that appears most appropriate. If you are unsure about which response to give to a question, the first response you think of is often the best one. Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life in the **last four weeks**.

	<u>Very Poor</u>	<u>Poor</u>	<u>Neither Poor nor Good</u>	<u>Good</u>	<u>Very Good</u>
a. How would you rate your quality of life?	1	2	3	4	5
b. How well are you able to get around?	1	2	3	4	5

D 23.		<u>Not at All</u>	<u>A Little</u>	<u>A Moderate Amount</u>	<u>Very Much</u>	<u>An Extreme Amount</u>
		<u>1</u>	<u>2</u>	<u>3</u>	<u>4</u>	<u>5</u>
	a. How much do you enjoy life?	1	2	3	4	5
	b. To what extent do you feel your life to be meaningful?	1	2	3	4	5
	c. To what extent do you feel that physical pain prevents you from doing what you need to do?	1	2	3	4	5
	d. How much do you need any medical treatment to function in your daily life?	1	2	3	4	5

	<u>Very Dissatisfied</u>	<u>Dissatisfied</u>	<u>Neither Satisfied nor Dissatisfied</u>	<u>Satisfied</u>	<u>Very Satisfied</u>
D 24.					
a. How satisfied are you with your health?.....	1	2	3	4	5
b. How satisfied are you with yourself?	1	2	3	4	5
c. How satisfied are you with your personal relationships?....	1	2	3	4	5
d. How satisfied are you with your sex life?.....	1	2	3	4	5
e. How satisfied are you with the support you get from your friends?	1	2	3	4	5
f. How satisfied are you with the conditions of your living place?.....	1	2	3	4	5
g. How satisfied are you with your access to health services? 1		2	3	4	5
h. How satisfied are you with your transport?	1	2	3	4	5
i. How satisfied are you with your sleep?.....	1	2	3	4	5
j. How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
k. How satisfied are you with your capacity for work?	1	2	3	4	5
D 25.	<u>Not at All</u>	<u>A Little</u>	<u>A Moderate Amount</u>	<u>Very Much</u>	<u>Extremely</u>
a. How well are you able to concentrate?.....	1	2	3	4	5
b. How safe do you feel in your daily life?.....	1	2	3	4	5
c. How healthy is your physical environment?.....	1	2	3	4	5
D 26.	<u>Not at All</u>	<u>A Little</u>	<u>Moderately</u>	<u>Mostly</u>	<u>Completely</u>
a. Do you have enough energy for everyday life?	1	2	3	4	5
b. Are you able to accept your bodily appearance?	1	2	3	4	5
c. Have you enough money to meet your needs?	1	2	3	4	5
d. How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
e. To what extent do you have the opportunity for leisure activities?	1	2	3	4	5
D 27.	<u>Never</u>	<u>Seldom</u>	<u>Quite Often</u>	<u>Very Often</u>	<u>Always</u>
How often do you have negative feelings such as blue mood, despair, anxiety, depression?.....	1	2	3	4	5

↓ ↓ ↓

IF YOU HAVE ADDITIONAL COMMENTS OR IDEAS YOU WOULD LIKE to SHARE WITH US, PLEASE USE the
SPACE BELOW & THE BACK OF THIS PAGE:

Appendix F – Personnel Receiving Pay from the Project

Quinn M. Biggs

Daniel W. Cox

Jessica Kansky

Natalie Kodsy

Allison Stuppy